Maternal and Child Health Services Title V Block Grant

State Narrative for Missouri

Application for 2011
Annual Report for 2009

Document Generation Date: Saturday, September 18, 2010

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Copies of the Title V Assurances and Certifications may be obtained by contacting:

Bret Fischer, Director
Division of Administration
Missouri Department of Health and Senior Services
PO Box 570
Jefferson City, MO 65102-0570.

Phone: (573) 751-6014
FAX: (573) 526-6049

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

Public input was obtained throughout the past year as part of routine staff communication and participation in coalitions, advisory boards, conferences, and professional and community meetings. For examples of the types of agencies and organizations involved see Section III.E. State Agency Coordination.

The Proposed Use of Funds for the Maternal and Child Health (MCH) Block Grant application was posted from April 30, 2010 to May 28, 2010 on the Department of Health and Senior Services's (DHSS) website (www.dhss.mo.gov). The Proposed Use of Funds was e-mailed to 337 various public contacts including council members, community partners, Local Public Health Agencies (LPHAs), health care professionals, and industry leaders. In addition, the Missouri Chapter of the American College of Obstetricians and Gynecologists forwarded the information to 450 of its members. Ads were placed in the St. Louis, Kansas City, Springfield, Columbia, Kirksville, and Cape Girardeau newspapers to notify the public of the document's location on the internet and the contact information to request hard copies.

The DHSS website with the Proposed Use of Funds had a total of 118 hits, 5 internal (includes LPHAs) and 113 external.

Responses were received from 35 individuals representing a wide variety of organizations and interests. Of those, 11 expressed their support for the maternal and child health activities proposed and 4 requested additional detailed information on overall MCH related activities.

General themes which appeared throughout the majority of the comments included the need to support oral health, injury prevention activities, prevention of teen pregnancy, adolescent health, and breastfeeding.

In particular, the Greater Missouri Chapter of the March of Dimes wrote:

"March of Dimes would like to applaud the Department's efforts to protect and improve the health of women and children across the state. Our newborn screening program is one of the strongest in the nation and in 2009 March of Dimes was proud to honor Missouri with the National Award for Excellence in Newborn Screening. The budgeted funds to maintain and improve these services are essential and we fully support the Department's work.

March of Dimes is also in favor of the Department's inclusion of services and infrastructure building to provide a network of care which will prevent birth defects, prematurity and infant mortality. Missouri has lowered its prematurity rate from 13.3% in 2005 to 12.3% in 2008 according to the National Center for Health Statistics. Many of the population-based services covered by the Title V Block Grant are related to these health issues - specifically, the programs on Folic Acid and Alcohol, Tobacco & Other Drugs Prevention and Awareness. Along with the infrastructure established through the grant, these services continue to protect the most vulnerable Missourians."

The Catholic Charities of Kansas City-St. Joseph, Inc. stated: "We are pleased with the diversity of services and programs supported through this funding source. We also appreciate our continued partnership with DHSS through the Adoption and Foster Care Coalition and the opportunity to continue to serve young families in Missouri."

Other individual comments focused on obesity, sickle cell, SIDS, home visiting and Parents as Teachers. All of the comments focused on areas which are specifically one of the 10 identified Missouri Priority Needs or on an activity which directly relates to one of the Priority Needs. Each comment was reviewed and responded to by the Title V Director. The input received from these comments has been incorporated into the plan where appropriate.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

In 2010, the Title V Agency for Missouri (Missouri Department of Health and Senior Services/Division of Community and Public Health) completed the statewide five-year maternal and child health and CYSHCN, needs assessment. The study was designed to enable Title V to assess its services in relation to the MCH needs of the state, which were identified through secondary data from the census, related data, population surveys, input from others in the community with expertise on the issues of the population served and focus groups with consumers and providers across Missouri. On April 6, 2010, 63 MCH "stakeholders" from across Missouri gathered in Jefferson City to review quantitative and qualitative data compiled towards the needs assessment. The stakeholders were presented with data from statewide focus groups and epidemiological trends on select MCH indicators to provide them with an idea of Missouri's standing with respect to national performance measures, current state performance measures and current state MCH priorities. The process yielded 14 MCH priorities that were scaled down to ten MCH priorities based on nominal ranking by stakeholders - all of which underscore the importance of a life course perspective rather than a fragmented approach to improve MCH. The top ten Missouri MCH priorities identified through the needs assessment process in relation to the MCH pyramid of health services are as follows:

INFRASTRUCTURE

Support Adequate Early Childhood Development and Education - Collaborate to coordinate efforts through a leadership role in an interagency coalition for the purpose of better targeting existing resources for early childhood development and education, identifying gaps in service delivery and infrastructure, and pursuing necessary resources to address these identified areas.

Improve the Mental Health Status of MCH Populations - Collaborate with state and local partners to develop/enhance mental health infrastructure. Identify strategies to streamline existing resources and integration of mental health services into primary care. Focus will be on preventive mental health services particularly among new mothers, children and adolescents.

POPULATION-BASED SERVICES

Reduce the Rate of Teen Pregnancies and Births - Collaborate with state, local and non-profit agencies involved with teen pregnancy prevention activities through technical and programmatic support. Focus will be on comprehensive education as part of the life course perspective to prevent teen births/pregnancies.

Prevent and Reduce Smoking Among Women and Adolescents - Collaborate with statewide partners to reduce the number of women and adolescents who smoke.

Reduce Obesity Among Women, Children and Adolescents - Collaborate with statewide partners to achieve healthy weight among the MCH population through increased physical activity and healthy eating habits.

Reduce Disparities in Adverse Birth and Pregnancy Outcomes - Collaborate with state and national partners to examine the causes of adverse pregnancy outcomes, particularly the associated racial disparities. Implementation of evidence based interventions and novel initiatives

with a life course approach will be the center piece to reduce disparities in birth outcomes.

Reduce Intentional and Unintentional Injuries Among Women, Children, and Adolescents - Collaborate with partners to implement environmental supports and policies to positively impact motor vehicle accidents/deaths among adolescents; suicide attempts/completions among adolescents; and intentional/unintentional injuries among women, children and adolescents.

DIRECT/ENABLING SERVICES

Improve Health Care Access for MCH Populations - Provide technical assistance and resources in collaboration with other statewide partners to assure adequacy and cultural competency of provider networks which support reproductive health, primary health, oral health, and mental health/substance abuse services for women, infants/children, adolescents, and special health care need populations, with an emphasis on medical/oral health home.

Improve Preconception Health Among Women of Childbearing Age - Collaborate with state and local partners on the importance of preconception care and the need to educate women on the importance of preconception care. Enhance public health education efforts encouraging women of childbearing age to seek preconception and interconception care as part of the life course perspective.

Enhance Access to Oral Health Care Services for MCH Populations - Collaborate with statewide partners to identify and address gaps in the oral health service delivery system; conduct oral health surveillance to inform the oral health systems enhancement initiatives; support the training and placement of oral health professionals in underserved areas to better meet the oral health needs of MCH populations; encourage the integration of oral health preventive services into primary care and school health settings.

MCH priorities no longer include:

-Reduction of Child Abuse and Neglect

-Enhance Environmental Supports and Policy Planning/Development for the Prevention of Chronic Disease (this priority is an integral part of the preconception priority)

MCH priorities that emerged for the first time in the 2010 MCH Needs Assessment:

-Reduction of Teen Pregnancies and Births

-Improvement of Preconception Health Among Women of Childbearing Age

These priorities establish a framework for the allocation of Title V MCH block grant resources over the next five years. While the importance of life course perspective is evident across all priorities, the overriding MCH priority need that emerged based upon data analysis, focus groups results, MCH stakeholders meeting and Missouri Title V programs was to improve access to care for MCH population groups in Missouri. Improved access to MCH services will require a much larger commitment of State resources beyond Title V MCH Block Grant funding.

III. State Overview

A. Overview

The Title V Maternal and Child Health (MCH) Agency in Missouri is the Department of Health and Senior Services (DHSS), Division of Community and Public Health (DCPH), Section for Healthy Families and Youth (HFY). The Section Administrator, Melinda Sanders, MSN, RN, serves as the Title V Director. Two principal bureaus for serving the MCH population are located within the section; Genetics and Healthy Childhood (GHC) and Special Health Care Needs (SHCN).

Title V related activities throughout DHSS support Missouri's health care delivery system across each of the four levels of the MCH pyramid (direct services, enabling services, population-based services and infrastructure building activities) as detailed further throughout this application (see the attached Missouri Core Pyramid of Services).

Following is a brief description of some physical, economic, and legislative areas which impact the health and well-being of the maternal and child populations.

Geography

Missouri is comprised of 115 counties\independent city covering an area of 69,709 square miles and ranks 21st in size among all states in the nation. The state is centrally located in the heartland of the United States and shares borders with Arkansas, Kansas, Kentucky, Illinois, Iowa, Nebraska, Oklahoma, and Tennessee. The two largest rivers in the state are the Mississippi, which marks the eastern border of the state, and the Missouri, which flows across the middle of the state. Two large metro areas, Kansas City and St. Louis are located on the western and eastern borders respectively and are connected by the "I-70 Corridor".

Demographics

In 2008, Missouri had a total population of 5.9 million and was ranked as the 18th largest state. From 2000 to 2008 the state's overall population increased by 5.6%. Those ages 65 and over, currently make up 13.6% of the state's total population. In the next several years, the 65 and over population is expected to increase to over 20%.

Missouri residents are predominately white (85.8%) with a significant African-American (11.9%) and a smaller Asian/Pacific Islander (1.7%) and American Indian (0.6%) population. Over 80% of Missouri's African-American population is located in the three largest counties (St. Louis City, St. Louis County, and Jackson County-Kansas City area). Hispanics represent a small but growing segment of the population, which is more broadly dispersed throughout the state and makes-up only 3.2% of the total population. Latino is the fastest growing sub-population in the state and has increased by 60% from 2000 to 2008. In 2008, Missouri's estimated MCH population including women of childbearing age (15-44), infants, and children and adolescents (1-19) was 2,566,154. This accounted for nearly half (43.4%) of the state population and showed a slight decrease of 1.1% from 1999.

Missouri's population reflects a dichotomy between its largest metropolitan statistical areas (MSA) (St. Louis on the east and Kansas City on the west) and its more rural areas. Missouri has 34 counties designated as MSAs. Over half of the state's population (55%) resides in the St. Louis and Kansas City MSAs. The St. Louis MSA, which includes St. Louis City, St. Louis County and six other counties, accounts for over one-third of the total state population. The Kansas City MSA, including Jackson County and eight other surrounding counties, accounts for nearly 20%. Missouri has 24 counties designated as micropolitan statistical areas. About half (57) of Missouri's counties (115) are not designated as either metropolitan or micropolitan areas.

Over the past few decades the majority of population growth occurred in the suburban areas of

Kansas City and St. Louis and in the more rural central and southwestern parts of Missouri. The population has either decreased or remained static in the urban cores of Kansas City and St. Louis, as well as the largely agricultural lands of northern and southeast Missouri.

According to the 2008 American Community Survey (ACS), 306,405 (5.6%) Missourians age five and above are estimated to speak a language other than English at home. Of that group, 125,855 persons (2.3% of the total Missouri population) speak English less than 'very well'. An estimated 138,268 (2.5%) Missourians use Spanish as the primary home language.

Economy

Missouri's metropolitan areas make up the largest portion of the state's economy. St. Louis County and Jackson County combined contribute nearly one third of the state's economy in terms of employment, personal income, and population. Despite the size, all of the regions have a role in the state's economic makeup. Missouri's rural areas are especially important to tourism and agriculture in the state. Much like the nation, Missouri's economy has experienced a downturn in the past few years. This trend can be seen in slumping manufacturing exports as the automotive and other industries have struggled.

Unemployment has also increased substantially. The unemployment rate rose from 5.8% in May 2008 to 9% in May 2009. The education and health services sectors had the largest growth between 2007 and 2008 with an increase of 5,900 jobs. The federal and local government sectors have also increased employment over the year. Manufacturing employment has been trending downward with declining employment in the housing and auto industries.

In 2008, 13.3% of Missouri's population had incomes below the federal poverty level. Missouri's poverty rate increased faster than the national average between 2001 and 2008 (11.7% to 13.2% for the US; 9.7% to 13.3% for MO). Between 1999 and 2008, the median household income in Missouri dropped by 14.6%, the steepest decline among all 50 states. The national decline in median household income was 2.5%. Missouri's decline was nearly six times faster than the national average. In FY2000, half of the households in Missouri had an income of more than $54,930. In FY2008, the midpoint was $46,906. Only to compound the issue, the U.S. Bureau of Labor Statistics calculates that a dollar in 2008 had the same buying power as 77 cents in 1999. Thus the median Missouri household in 2008 had 34% less buying power than it did nine years earlier. The median household income figures were compiled from Census Bureau data by the Robert Wood Johnson Foundation as part of the report "Barely Hanging On: Middle Class and Uninsured". The report showed that the rising costs of health care had a great deal to do with the loss of household purchasing power for the middle class. More than one in 10 of all Missourians covered by employer-sponsored health insurance lost that coverage in the study period.

For the 12 months ending September 2009, there were 378 St. Louis business bankruptcies. This was up nearly 19% from the year before and nearly 25 times the number of filings two years prior. The St. Louis trend is reflected in other parts of the state.

Homelessness

Homelessness is a problem for both rural and urban Missouri. In 2006, an estimated 5,067 rural Missourians were homeless. Nine hundred fifty-nine were categorized as victims of domestic violence, substance abuse, or those with mental illness. Missouri was ranked 41st in the nation for the number of homeless children in 2005-2006. Of the 256,000 children living in poverty, and estimated 12% are homeless. In 2005-2006, an estimated 30,478 children were homeless throughout the state. Of those, an estimated 12,801 were under 6 years old.

Transportation

Missouri's transportation system was ranked 6th best in the nation in 2009. It has 3 key

transportation measures: railroad mileage, waterway mileage, and airports. With the nation's 7th largest highway system, the high quality of Missouri's infrastructure gives Missouri businesses efficient accessibility to major markets for distribution needs and telecommunication. Access to public transportation is limited in the rural areas. There are few mobility options for residents without access to automobiles.

Health Care Coverage

In 2008, an estimated 6.8% of children (under 18) and 16.3% of women (ages 18-44) were without health insurance in Missouri. The estimated percentage of employment-based health insurance in Missouri decreased from 71% in 2002 to 64% in 2008 for children and was essentially unchanged for women (65% vs. 66%). The percentage of children under 18 without health insurance in Missouri has been consistently lower than that of the nation (6.8% vs. 9.9% in 2008), and has steadily increased from 4.7% in 2001 to 10.5% in 2007, but decreased to 6.8% in 2008.

Medicaid covers 34% of Missouri's children and pays for about 47% of all births in the state. Children represent the largest demographic group served by Missouri Medicaid, with 58% of all Medicaid enrollees being age 18 or younger. Approximately 26% of Missouri's total budget went to Medicaid in State Fiscal Year (SFY) 2009.

The Medicaid program in Missouri provides health insurance coverage for children under age 19 whose net family income does not exceed: 185% of FPL for children under age 1, 133% of FPL for children ages 1-5, and 100% of FPL for youth ages 6-18. Approximately 547,254 low-income Missouri children have health insurance coverage through this program.

Using the State Children's Health Insurance Program (SCHIP) funds, Missouri expanded its existing Medicaid program for low-income children in 1998. This SCHIP expansion extended health coverage to low-income children with family income up to 300% of FPL. The SCHIP program provides the same health services as those covered under Medicaid, except that children covered by SCHIP are not eligible for non-emergency medical transportation. Based on an income scale, some individuals covered under Missouri's SCHIP program must pay premiums. Premiums paid per family per month range from $12 to $300. Approximately 118,591 children have coverage under the SCHIP program in Missouri. This number represents 7% of the total Medicaid population.

Pregnant women with family incomes up to 185% of FPL qualify for Medicaid coverage. Qualification under this category includes 60-day postpartum coverage even with subsequent increases in family income. Approximately 27,000 women received insurance benefits under this program during SFY 2008. This group represents 3% of all Medicaid recipients in the state.

Medicaid provides access to services through either the fee-for-service system or the managed care system. In Missouri, all individuals eligible under Medicaid for the Aged, Blind, and Disabled program participate in the fee-for-service system regardless of their county of residence. Additionally, children and parents that live in counties other than those designated as managed care counties participate in the fee-for-service system.

The Medicaid managed care system started in 1995. Effective January 1, 2008, Missouri's Medicaid Managed Care program expanded into 17 additional counties. The managed care system now operates in a total of 54 counties across the state. These counties are located along the "I-70 Corridor". All Medicaid recipients must enroll in a managed care health plan if they reside in one of the 54 counties included in the managed care system and if they fit into one of the following eligibility categories: parents/caretakers, children, pregnant women, and refugees; other Medicaid children who are in the care and custody of the state and receive adoption subsidy assistance; and children covered by SCHIP. Approximately 380,000 Missourians were enrolled in one of the six contracted Medicaid Managed Care Plans as of June 2008.

Managed care programs work on various Performance Improvement Projects throughout the year. This year some of the areas of focus have been asthma, ER use, immunization (free transportation and outreach at community events), lead (community events and letters to parents), adolescent health, EPSDT screens, hi-risk OB care, dental care, and one plan worked on a Medical Home project. More specific details on several of these activities can be found in the applicable performance measures.

Environment

Lead mining and smelting is an important part of Missouri's history. Missouri became the dominant lead-producing state in the nation in 1907. It has remained number one ever since. The most common sources of lead poisoning are lead dust; lead in soil; and peeling, chipping or cracking lead based paint. Lead-based paint was banned from residential use nationwide in 1978. Any home built before 1978 may contain leaded paint. The highest risk of lead exposure for children is found in homes built before 1950, when most paint contained a high percentage of lead. More than 23.6% of the housing stock in Missouri was built before 1950. Sixty counties in Missouri have greater than 23.6% pre-1950 housing stock.

The number of Missouri's children younger than six years old who have been tested for lead exposure annually has increased from 50,362 in 2000 to 93,739 in 2009. Of the number of children tested, the percentage found to have elevated blood lead levels has declined from 11.1% in 2000 to 1.1% in 2009. This decrease mirrors a nationwide decrease in children's blood lead levels. In 2009, of the 93,739 children in Missouri who received a blood lead test, 1,071 (1.1%) had a blood lead level of 10 µg/dL or greater.

The Childhood Lead Poisoning Prevention Program (CLPPP) within the Division of Community and Public Health (DCPH) is a Center for Disease Control and Prevention (CDC) funded program. The Missouri program was established in 1993. The program's mission is to assure the children of Missouri a safe and healthy environment through primary prevention, detection, surveillance and case management for lead exposures that may cause illness or death. Passed in 2001, RSMo 710 required DHSS to promulgate rules and regulations to establish a statewide screening plan. The rules and regulations define criteria for establishing geographic areas in the state considered to be at higher risk for lead poisoning; outline blood lead testing requirements and protocols; and define lead testing follow-up and treatment procedures. In developing these regulations, CLPPP applied Missouri surveillance and census data to establish criteria for Universal Testing (high-risk) areas in Missouri.

Major Legislative Initiatives

2010 Missouri Legislative\Budget Session

The 2010 Legislative Session in Missouri closed without passage of a number of bills considered to be "key" in addressing the state's budget situation and a number of the Governor's priorities. In total, 118 pieces of legislation were truly agreed to and finally passed in this session, and some of the successful bills are as follows:

HB1764 creates a referendum that puts the new federal health insurance mandate to a vote of Missouri residents on the August 3, 2010 ballot. Voters will decide whether the people and employers of the state can/cannot be compelled to have health insurance. The legal impact of the state measure is questionable, because courts generally have held that federal laws supersede state laws.

HB1270 changes the name of the Crippled Children's Program to Children's Special Health Care Needs. This piece of legislation has been proposed numerous times in the past 12 years and we are very happy that it was successful this year.

HB1311 & 1341 mandate insurance coverage for individuals with autism spectrum disorders. This bill also prohibits a carrier from denying or refusing to issue insurance coverage on, refusing to contract with, refusing to renew or reissue coverage on, or terminating or restricting coverage on an individual or his or her dependent because the individual is diagnosed with Autism Spectrum Disorder (ASD). In addition, this bill requires insurance carriers to pay for applied behavior analysis for individuals younger than 19 with a maximum benefit of $40,000 per year, adjusted annually.

HB1375 allows expedited partner therapy. This bill allows a licensed physician to use expedited partner therapy under certain conditions by dispensing and prescribing medications for the partner of a person diagnosed with certain sexually transmitted diseases even when there is no existing physician/patient relationship.

HB1472 adds 1-pentyl-3-(1-naphthoyl) indole, commonly known as K2 as a Schedule I controlled substance. This substance has been popular especially among adolescents as it has been available without any restrictions and provides users a "marijuana-type" effect.

HB1695 strengthens reporting designed to better identify repeat offenders, provides greater accountability and transparency for court actions, enhances the use of DWI courts and includes language helpful to enforce actions. This bill was signed by the Governor on June 4, 2010 and becomes law on August 28, 2010.

HB2270 allows child abuse medical resource centers and providers receiving training from the Sexual Assault Forensic Examination-Child Abuse Resource Education (SAFE-CARE) network to collaborate directly or through the use of technology to promote improved services to children who are suspected victims of abuse and need a forensic medical examination by providing specialized training for forensic medical evaluations in a hospital, child advocacy center, or by a private health care professional without the need for a collaborative agreement between the child abuse medical resource center and a SAFE-CARE provider.

SB793 expands the information required to be provided to women 24 hours before abortions, including the option of viewing an ultrasound and listening to a heartbeat of the fetus.

Some of the bills failing to pass this year include:

Reducing the benefits of state employees - fewer state holidays and requiring new employees to contribute 4% of their pay to the retirement system and they would not have been eligible for retirement until later than allowed under current law.

Several measures sought to ban all Missouri drivers from sending cell phone text messages while driving. Currently, only persons 21 years of age and younger are banned from texting while driving.

Various proposals would have created new tax incentives for manufacturers that retain jobs by improving their factories; granted Missouri businesses an edge in getting existing tax incentives; and used a portion of the taxes from technology companies to recruit other such firms.

Gov. Jay Nixon, Senators and House Democrats pushed for new limits on state tax credits, but House Republicans refused to consider the reductions.

People receiving state cash assistance would have been required to pass drug tests or lose benefits, and elected state officials would have faced a similar requirement.

Perhaps the most significant pieces of legislation that resulted from the 2010 Legislative Session was the state budget for the FY2011 fiscal year which begins on July 1, 2010. It is anticipated the

state budget for FY2010 will end $1.5 billion less than revenues. As a result, the Governor has with-held current year funds from virtually every Department in state government. Medicaid reimbursement rates have been reduced, the Parents as Teachers program has been reduced, vacant state employee positions have been "held", and programs anticipating a lapse in funding have been "swept". In addition, the Governor announced the budget sent to him by the General Assembly for FY2011 is predicted to be $350 million short. Thus, all Departments once again are anticipating with-holdings of funds at the start of the next fiscal year. The Department of Health and Senior Services, Division of Community and Public Health finds ourselves in a even more precarious position-the Division's budget for FY2011 was not finalized by the General Assembly. It is anticipated that the Governor will communicate both with-holds and finalization of the Division's budget closer to July 1, 2010. The Division does anticipate state employees will be required to be laid-off, but the exact numbers are unknown at this time.

2009 Missouri Legislative Session

HB 716 was passed which was enacted as RSMo 191.711.1. The legislation required the DHSS to prepare written educational publications with information about possible complications, proper care and support associated with premature infants; to distribute the materials to children's health and maternal care providers, hospitals, public health departments, and medical organizations; and to encourage those organizations to provide the publications to parents or guardians of premature infants.

The Department's Bureau of Genetics and Healthy Childhood worked collaboratively with birthing and children's hospitals that have neonatal intensive care units to evaluate educational materials currently in use and to determine which materials would be best to use on a statewide basis. Medimmune, the maker of Synagis, the vaccine indicated for the prevention of serious lower respiratory tract disease caused by respiratory syncytial virus (RSV), had been instrumental in getting this legislation passed in Missouri and some other states. Medimmune offered the Department educational materials they had developed to educate parents of premature infants on a variety of topics. After reviewing their materials a decision was made to use six of their handouts and to include three provided by the Department, which included a Resource List for Parents of Premature Infants, a brochure on "Baby Blues," and a Car Seat Safety Card for Premature Infants. All of these materials are posted on the Department's website.

Legislation was passed that expanded the newborn screening (NBS) panel to include testing for five lysosomal storage disorders (LSD's): Krabbe disease, Gaucher's disease, Niemann-Pick disease, Pompe disease, and Fabry's disease. These disorders are to be added to the NBS panel by July 1, 2012. The Newborn Screening Program anticipates that a pilot program will start in early 2011. Missouri will be the first of two states to screen for five of the LSDs at once and when implemented will be a leading state in the nation for newborn screening. Additional lysosomal disorders (over 35 of them) can be added as technology allows.

Challenges to the Delivery of Title V Services

The impact of a declining economy can be felt across various U.S. public and private sectors, including public health, and MCH is no exception. With declining revenues, states are forced to cut/reduce services and staff that are critical to run MCH programs. Missouri is no different than the rest of the nation and is facing the brunt of a poor economy and lack luster job market. MCH priority needs will be competing for funds with a growing host of other state priorities resulting from the state budget shortfall and reductions. In addition, the number of individuals qualifying for services will increase as the economy and job market decline.

According to the Robert Wood Johnson Foundation report "Shortchanging America's Health" in FY 2008-2009 Missouri spent just $9.26 per resident in State funds for public health. Of the 50 states and the District of Columbia, only one state spent less. The national median average was $28.92 per capita.

Along with a shortage of primary care providers, there are geographic, insurance, transportation, and other structural barriers to the access of primary medical care. Of the 115 counties in Missouri, 100 are currently designated health professional shortage areas (HPSA). Further, Missouri's increasingly diverse cultures, struggling economies and limited financial and human resources influence efforts to address disparities and the quality of health care services.

The delivery of oral health education, prevention, and treatment continues to be a challenge. One barrier is a shortage and maldistribution of dentist. For instance, 2010 licensure data indicates 3,327 dentists are licensed in Missouri, however only 2,437 are actively practicing in the state, with the majority located in metropolitan areas. Further, very few dentists accept Medicaid as evidenced by 2009 Medicaid claim data, which indicates 234 (9%) of dentists were enrolled as Medicaid providers. Of the 234 Medicaid dentists, 67 (28.6%) had one or more Medicaid claims in 2009. This leaves the vast majority of the approximately 500,000 children enrolled in Medicaid without a dental home.

Barriers to delivering oral health related education and services include the lack of understanding and buy-in regarding the impact of oral health on overall health; such as the management of diabetes, cardiovascular disease, and improving maternal and infant health outcomes. Missouri's oral health program does not receive general revenue funding and relies solely on Title V funding to sustain programming.

Public transportation is limited in most of the rural areas of Missouri. Although Medicaid provides transportation to scheduled medical appointments for Medicaid eligible individuals, those services are only available with three days notice. Therefore, many low income women and children have limited access to transportation to medical appointments of a more immediate nature.

In addition, a challenge to both medical and dental primary care is health literacy. Often vulnerable populations do not possess adequate health literacy skills to implement recommended action steps; this is overlooked by many health professionals and their staff that may be providing information.

Changes to the MCH Services contracts with Local Public Health Agencies (LPHAs) involve shifting from service delivery to working with community partners for systems building and sustainability in addressing MCH priority health issues. Examples of challenges for urban MCH contractors addressing obesity prevention are the lack of access to affordable fresh produce and safe environments for physical activity. Rural communities lack sidewalks and very often lack the resources available in urban areas.

The Public Health Burden Report of Traumatic Brain Injuries in Missouri completed in March 2007 identified children ages 0-4 years as being one of two populations with the highest rates of hospitalization and emergency room visits for traumatic brain injury (TBI) in Missouri. Children acquiring a TBI in early childhood live with the effects of TBI their entire life. The Missouri 2004 TBI Needs and Resource Assessment identified limited public knowledge of TBI as being a major barrier to services for the preschool population.

Department Priorities and Initiatives

The activities of the Missouri Department of Health and Senior Services (DHSS) are focused around four main goals listed in the DHSS Strategic Plan 2010.

1. Increase Commitment to and Investment in Health
2. Improve Health and Health Care Delivery
3. Ensure that Our Consumers are Safe and Healthy
4. Achieve Optimal Productivity, Efficiency and Effectiveness.

Every five years, as part of the MCH Block Grant a statewide needs assessment is conducted. State MCH Priority Needs and Performance Measures are revised based upon this assessment. In 2009/2010, focus groups met in 13 locations around the state. In addition, a maternal and child health statewide stakeholders meeting was conducted in April 2010. Based on the needs assessment process, Missouri has identified the top ten state MCH priorities which will be the focus of the next five years. Woven throughout these priorities is an overarching life course perspective. Many of the state performance measures have been revised in an attempt to incorporate the interplay of early life events on later health.

Missouri's 2010 MCH State Priorities are:

1. Improve health care access for MCH populations
2. Prevent and reduce smoking among women and adolescents
3. Reduce obesity among women, children and adolescents
4. Improve the mental health status of MCH populations
5. Enhance access to oral health care services for MCH populations
6. Improve preconception health among women of childbearing age
7. Reduce the rate of teen pregnancies and births
8. Reduce disparities in adverse birth and pregnancy outcomes
9. Reduce intentional and unintentional injuries among women, children and adolescents
10. Support adequate early childhood development and education

Each year, as a part of the MCH Grant process, proposed requests for the use of MCH funds are submitted to the Title V Director. The requests are evaluated based on the MCH State Priorities and on a weighted score for each of the nine factors listed below.

1. Size of the problem (population affected)
2. Seriousness of the problem (morbidity/mortality)
3. Availability of interventions
4. Effectiveness of interventions
5. Economic feasibility
6. Community perception of the problem
7. Acceptability of the intervention to the public
8. Political issues related to the problem
9. Propriety/scope of responsibilities (public health role)

Information from the process above is used by the Title V Director, Division of Community and Public Health Director's Office and the Department of Health and Senior Services Director's Office to prioritize the use of Title V funds in the state.

B. Agency Capacity

State Statues

On March 29, 1883, the Missouri Legislature established a state agency responsible for promotion of health and prevention of disease by creating the State Board of Health. Missouri Crippled Children's Service became part of the Division of Health, Department of Social Services in 1974. The Department of Health (DOH) was created in 1985 to supervise and manage all public health functions and programs formerly administered by the Division of Health. Executive Order 01-02 in 2001 transferred the Division of Aging to DOH and the formed Department of Health and Senior Services (DHSS) allowing one department to focus on prevention and quality of life.

RSMo 201 requires the DHSS "to administer a program of service to children who are crippled or who are suffering from conditions that lead to crippling." "The purpose of this service is to develop, extend, and improve services for locating such children, especially in rural areas, and for

providing medical, surgical, corrective and other services and care facilities for diagnosis, hospitalization, and aftercare." This requirement is met through the Children and Youth with Special Health Care Needs Program (CYSHCNP).

RSMo 191.331 passed in 1965 requires every infant born in Missouri be tested for phenylketonuria and such other metabolic or genetic diseases as are prescribed by the department. RSMo 191.332 expanded screenings in 2005 to include cystic fibrosis, biotinidase deficiency, and amino acid and fatty acid disorders.

Missouri has met the goal of screening for all 29 core conditions (including hearing) recommended by the American College of Medical Genetics, the March of Dimes and the Missouri Genetic Advisory Committee. When considering secondary conditions, a total of 67 disorders can now be detected through Missouri's newborn screening program.

RSMo 191.331 was amended in 2007 to expand financial eligibility guidelines for children through age 18 to receive metabolic formula. Any child under age 6 is financially eligible to receive metabolic formula and those children from age 6 through 18 are eligible at 300% of federal poverty level (FPL). DHSS established rules to implement this statutory provision to provide a sliding scale for family incomes exceeding 300% of the FPL so no family pays more than 50% of the cost of formula.

RMSo 191.925 became effective January 1, 2002 and requires Missouri hospitals to screen newborns for hearing loss prior to discharge. RMSo 191.928 includes: the maintenance of a newborn hearing screening surveillance and monitoring system; and the establishment of follow-up procedures to assure appropriate and timely diagnosis of hearing loss, delivery of amplification, and referral for early intervention services.

Funding appropriated in 2004 allowed dental hygienists to bill Medicaid/SCHIP for services rendered under expanded scope of practice per RSMo 332.311 allowing duly registered and currently licensed dental hygienist with at least 3 years of experience, practicing in a public health setting, to provide Medicaid eligible children: fluoride treatments, teeth cleaning, sealants without supervision of a dentist.

RSMo Section 630 incorporates Senate Bill 1003 (Child Mental Health Reform Act) to create the Comprehensive Children's Mental Health Service System to serve children with emotional and behavioral disturbance problems, developmental disabilities and substance abuse problems. By August 28, 2007, and periodically thereafter, the Children's Services Commission shall conduct evaluations of implementation, effectiveness of the system, family satisfaction and progress of achieving outcomes.

House Bill 579 in 2007 transferred the State Emergency Management Agency from the Office of the Adjutant General to the Department of Public Safety for deployment of any health care professional licensed, registered or certified in Missouri or any other state and volunteers during emergency declared by the Governor. RSMo 44.105 granted volunteers immunity from civil damages for their services. DHSS is allowed to recruit, train and accept services of citizen volunteers to dispense medication in a public health emergency.

In 2007 RSMo 191.317 was amended to approve releasing results of newborn screening tests to child's health care professional. Prior to this family permission had to be given.

RSMo 191.733, effective 07/01/92 states the Department of Health and Senior Services shall establish and maintain a toll-free information line for the purpose of providing information on resources for substance abuse and treatment and for assisting with referral for substance abusing pregnant women.(L.1991 S.B. 190&5).

The Missouri School-Age Children's Health Services program, established through RSMo

167.603 in 1994 and funded in 1995 has enabled the Department to provide funding to local public school districts and/or local public health agencies for population-based health services for all school-age children in their local jurisdictions.

OVERARCHING CAPACITY

Access to Care

The Missouri Office of Primary Care and Rural Health (OPCRH) operates the Primary Care Resource Initiative for Missouri (PRIMO) program, which allows for the development and implementation a system of coordinated health care services available and accessible to all Missouri Citizens. The PRIMO program was designed as coordinated incentives to increase the number of primary health care professionals and health care delivery systems in areas of need within the state. This is accomplished through funding primary dental, medical, and behavioral healthcare within safety net settings, providing student loans to aspiring health professionals that agree to work in heath professional shortage areas (HPSA), and providing loan repayment to professionals agreeing to work in HPSAs. PRIMO funds are also utilized to assist with physician and dentists salaries. Additionally, the Rural Health Office provides funding to small rural hospitals and critical access hospitals through contracts to improve quality of care processes (particularly around trauma), customer service, and electronic medical records. These aspects are vital to assure vulnerable populations in rural areas are receiving adequate and timely care.

Early Childhood

The Early Childhood Comprehensive Systems (ECCS) grant resides within the Title V agency in Missouri. The focus is a statewide early childhood comprehensive system that supports families and communities in their development of children that are healthy and ready to learn at school entry. Serving as the guiding body is the ECCS Steering Team which includes representatives of DHSS, Department of Social Services, Department of Elementary and Secondary Education, Department of Mental Health, Head Start Collaboration Office, Children's Trust Fund, and the United Way among others. The ECCS project has a contract with the University of Missouri Kansas City - Institute for Human Development to develop a network of local community groups and a Parent Leadership Resource and Referral Clearinghouse. Eighteen local teams are at various stages of development across the state with work just beginning on the development of the parent leadership component.

Childcare

The Section for Child Care Regulation (SCCR) is responsible for licensing of family and group child care homes and child care centers, staff qualifications, quality initiatives, and inclusion services.

The Child Care Health Consultation (CCHC) is a collaborative effort between DHSS and LPHAs to provide health and safety consultation/education to child care providers, parents of children in child care and young children. CCHC assists families and child care providers to access needed health and social service programs, to interpret and implement services for CYSHCN and help prepare health care action plans for children in the child care settings. For example, the CCHC program provides information and referral to Medicaid, developmental screening, WIC, special needs service providers, lead screening/treatment, and other MCH services/programs.

PREVENTIVE AND PRIMARY CARE SERVICES FOR PREGNANT WOMEN, MOTHERS AND INFANTS

Newborn Screening

Missouri's newborn screening program consists of both bloodspot screening and newborn hearing screening. All infants born in Missouri are to be screened unless the parent declines for religious reasons. Early identification and timely intervention by health care providers reduce associated mortality and/or morbidity. The DHSS contracts with four genetic tertiary centers and four accredited cystic fibrosis (CF) centers located in St. Louis, Columbia, and Kansas City to follow-up on abnormal newborn screen results and ensure that confirmed infants are entered into a system of health care. Contracting with these centers greatly improves the outcomes of confirmed positive infants because the primary care provider is: provided accurate information about the disorder; instructed on the appropriate tests for a timely diagnosis and is urged to have the family come to the genetic center as soon as possible; and given instructions on how to treat the child until the child is seen in a genetic or CF center. These centers provide a full complement of medical specialists including genetic and medical evaluations, nutritional and dietary counseling, genetic counseling, and education to the parents about the child's disorder and treatment.

The Missouri Newborn Blood Spot Program (MNBSP) provides the names of infants confirmed positive for CF to the Bureau of Special Health Care Needs (SHCN). SHCN information is mailed to the parent explaining services available through the bureau.

Hearing screeners in hospitals and birthing centers refer infants not passing the initial hearing screen for further screening or for testing by a pediatric audiologist. Follow-up coordinators in DHSS track infants who did not have an initial hearing screen, did not receive a pass result on the initial screen, or are found to be at risk for later development of hearing loss. They will contact the birth hospital, parents, or audiologists as necessary to assure the child is receiving the appropriate care. Infants with hearing loss are referred to the IDEA Part C (First Steps) for appropriate interventions. Missouri is fortunate to have four schools for the deaf where infants and children may receive the type of assistance the family chooses.

Written correspondence targets the parents of infants born with spina bifida, Down syndrome, or a cleft defect to assure they are aware of resources to enhance the development of their child. Families are invited to contact the Bureau of Genetics and Healthy Childhood (GHC) or the DHSS Birth Defects website for further information.

Home Visiting

The Building Blocks of Missouri (Missouri's Nurse Family Partnership) Nurse Home Visiting Program and the Missouri Community-Based Home Visiting Program, Newborn Health Program provide education to women on the prevention of birth defects and how to decrease the incidence of preterm births through the daily use of folic acid and by avoiding alcohol, tobacco, and other drugs preconceptually and throughout pregnancy. The education of the clients is also instrumental in decreasing infant deaths due to unsafe sleep practices and shaken baby syndrome, decreasing the rates of prematurity due to inadequate prenatal care and birth spacing less than 18 months apart, and decreasing the incidence of preventable childhood diseases through immunizations. The Building Blocks of Missouri (Missouri's Nurse Family Partnership Program) Nurse Home Visiting Program and the Missouri Community-Based Home Visiting program serve up to 575 pregnant and parenting women at any given time providing them with assessment and primary prevention services.

Alternatives to Abortions (A2A) Program

The A2A program consists of services or counseling to pregnant women and continues for one year after birth to assist women in carrying their unborn children to term instead of having abortions, and to assist women in caring for their dependent children or placing their children for adoption. The program provides: prenatal care; medical and mental health care; parenting skills; drug and alcohol testing and treatment; child care, and newborn and infant care; housing and

utilities; educational services; food, clothing, and supplies relating to pregnancy, newborn care, and parenting; adoption assistance; job training and placement; establishing and promoting responsible paternity; ultrasound services; case management; domestic abuse protection; and transportation.

Newborn Health

The Baby Your Baby website (http://www.dhss.mo.gov/babyyourbaby) provides information for pregnant women, their families, and communities on healthy pregnancies, healthy babies and interconceptional care. The site includes a wide range of topics including early prenatal care, immunizations, well child checkups, special health care needs, preconception health care, folic acid to reduce the risk of birth defects, avoidance of alcohol, tobacco and other drugs, and promotion of best practices. This website will remain active through January 2013.

Baby Your Baby Books are disturbed statewide to Local Public Health Agencies (WIC and prenatal clinics), health care providers, hospitals, Federally Qualified Health Centers (FQHCs), Parents as Teachers (PAT) educators, Early Head Start programs, insurance providers, and other primary care facilities. The books provide Missouri specific resources in English and Spanish.

PREVENTIVE AND PRIMARY CARE SERVICES FOR CHILDREN AND ADOLESCENTS

Oral Health

The Oral Health Program (OHP) implemented the Preventive Services Program (PSP) a community-driven, systematic approach to population-based prevention of oral disease. The goal of the program is to assess the oral health status of children while providing a public health preventive intervention. The program involves local dentists and hygienists conducting an oral screening annually on as many children in the community as possible, accompanied by oral health education, application of fluoride varnish, and referral for necessary dental work to local clinicians. The OHP provides the fluoride varnish supplies and local dental professionals supply the manpower to accomplish this community-based approach.

School Health

The Missouri School-Age Children's Health Services program provides funding to districts with "highest need and least ability to afford" as demonstrated by level of children living in poverty and availability of school nurses. Prior to implementation of this program, 268 (50%) public schools were without routine health services. In 2010, six small rural school districts representing less than 500 children are without services. The local programs are advised by School Health Advisory Committees, composed of community members, health professionals, local public health staff, parents, and school staff.

Funding for school health services is offered through a performance based contract with work plans developed to address access to care, oral health promotion, obesity prevention, smoking cessation, injury control, mental health promotion, and management of CYSHCN including children with chronic conditions. This program represents 270,000 school age children and is in 97 of the 113 counties. A contract performance measure requires all participating school districts to increase the number and percent of children with a medical home, dental home, and referral completions for sensory screenings on an annual basis. Technical assistance is provided to school health staff related to social marketing, health literacy, and cultural competency. School contractors have strong partnerships with local public health agencies and work collaboratively to address MCH indicators.

Injury Prevention

The Injury and Violence Prevention Program provides targeted prevention interventions to children ages 0-14 through contracts with eight Safe Kids Coalitions. These coalitions provide services in fifty-one counties and the cities of St. Louis and Kansas City. Services include child passenger safety, bicycle safety, fire safety, crib safety, water safety, poisoning, and other prevention activities based on community need. Safe Kids Coordinators are based in a lead agency in the community such as a hospital or local health center and work closely with other community partners. From 2004 to 2009 Think First Missouri provided education to students in grades 7 through 12 regarding head and spinal cord injuries.

Telehealth

The Telehealth Medicine Program, located in southern Missouri, provides patients the option of being seen in a location close to home. It is designed to enhance genetic and other medical services and education in Missouri's genetic services program. Patients and families are provided outreach services that they might not otherwise receive because of the financial expense associated with traveling to central Missouri. It allows endocrine and nephrology patients the ability to take a more active role in the management of their health care. There are three Telehealth medicine clinics where patients are seen for genetic, endocrine and nephrology disorders. Services provided at these three clinics include physician consultation, genetic counseling, and nutritional counseling.

The Telehealth Medicine Program has expanded its services to 18 counties to provide services to families who have a child either with an autism spectrum disorder or a neurological disorder. These counties are located in the western, northern, central, and southern regions of the state.

Adolescent Health Program (AHP)

AHP addresses various adolescent health status indicators and issues. The program provides consultation education, training, and resources to assist health professionals, school personnel, parents, adolescents, state agencies, and community agencies. AHP consults with many DHSS programs to increase capacity and expertise in adolescent health. Council for Adolescent and School Health (CASH) assists DHSS in identifying adolescent health priorities and promoting strategies to reduce health risks to adolescents. CASH has advised on national efforts as well, including the Healthy People 2020 objectives. AHP contracts for services of board-certified adolescent medicine specialists provide consultation, specialized training for health professionals, and education through a newsletter disseminated to 6,000 professionals statewide and available online. Teen Outreach Program (TOP) contracts support local efforts to promote healthy youth development, improve academic outcomes, and reduce teen pregnancy. AHP coordinates three collaborative projects to promote evidence-based teen pregnancy, STD, and HIV prevention and preconception health for adolescents.

The AHP contracts for adolescent medicine consultation and educational programs for health professionals, school personnel, parents, adolescents, community organizations, and state agencies (social services, education, mental health, transportation). AHP also contracts with school, community, and faith-based organizations to implement abstinence education and youth development programs for adolescents and parent-child sexuality education programs.
In 2006 and 2009, DHSS completed an adolescent health system capacity assessment across 30 programs and services for adolescents (ages 10-24) and their families. Based on the results of the assessment, the DHSS Adolescent Health Leadership Team was formed to strengthen capacity and coordination of DHSS services and programs and serve on the Council for Adolescent and School Health (CASH).

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS (CYSHCN)

Special Health Care Needs Program (SHCN) develops, promotes and supports community-based systems that enable the best possible health and highest level of independence for Missourians with special health care needs. SHCN provides services for children and adults with disabilities, chronic illnesses and birth defects. Services include in-home assessments, authorization of treatment, and service coordination. SHCN promotes family-centered, community-based, coordinated care. Activities are focused around National Performance Measures and HRSA's 6 Key Systems Outcomes for children with special health care needs related to medical home, insurance coverage, screening, organization of services, family participation\satisfaction, and transition to adulthood.

Children and Youth with Special Health Care Needs Program (CYSHCNP) is administered through SHCN to provide early identification and health services, including service coordination for participants birth to age 21. The name of the program was changed in March 2010 to CYSHCNP to better reflect the population served.

Administrative Case Management (ACM) is provided through an agreement SHCN has with the Department of Social Services, MO HealthNet Division, the Medicaid agency for Missouri. SHCN authorizes medically necessary in-home nursing services and provides service coordination for participants in the Healthy Children and Youth (HCY) Program and the Physical Disabilities Waiver (PDW) Program. HCY participants are under the age of 21 and PDW participants are age 21and over.

The Service Coordination Model is used to articulate the service coordination process. Attached to this section is the SHCN Service Coordination Model. Service Coordinators (SCs) are located within each participant's region and complete the Service Coordination Assessment (SCA) in collaboration with participants/families to determine individual and family strengths, needs, and unmet goals. Participants/families are linked with healthcare and community services at the local level. The SCA is a person centered, comprehensive assessment, which includes assessing National Performance Measures related to CYSHCN. It was developed with participants/families to achieve the best possible health and highest level of independence for SHCN participants. In addition, transition plans are completed by SCs with participants/families and team members (health care professionals, school personnel, state or community agencies, etc.) to address participants' needs.

Additional providers are recruited to improve availability of services to participants. SHCN places provider enrollment forms on Internet and maintains provider enrollment information in the Missouri Health Strategic Architecture and Information Cooperative (MOHSAIC) system for access by SCs.

Through a contract with Missouri Assistive Technology, SHCN provides home access improvements, vehicle access, and a range of assistive technology devices for CYSHCN.

The Adult Head Injury Program facilitates the Missouri Head Injury Advisory Council (MHIAC) which makes recommendations for improvement of systems to meet needs of those with traumatic brain injury (TBI) and serves in advisory role to the Federal TBI Implementation Grant awarded to DHSS. This grant is funded through the Health Resources and Services Administration for 2009-2013 with the overall goal "to provide individuals with traumatic brain injuries and their families with improved access to comprehensive, multidisciplinary, coordinated and easily accessible systems of care." Through this grant, SHCN and Missouri Head Start are in the early stages of a partnership to provide education, training and information dissemination to increase public awareness and enhance service delivery to this underserved population. DHSS will continue to identify systems that provide services to this population and develop partnerships throughout this grant to work towards a comprehensive system of care for this population.

SHCN collaborates with external entities to: increase organization of community-based service systems; determine participants' current Medicaid status; receive referrals of children applying for

SSI from the State Disability Determination Unit (DDU); and coordinate statewide, multi-agency efforts for participation in local, regional and state disaster response planning activities.

Through the Section for Child Care Regulation (SCCR), Child Care Resource and Referral (CCRR) provides referrals for families to child care programs. Referral Specialists collect data (immunizations, diseases, birth defects, developmental issues and insurance status, etc.). Inclusion Specialists ensure appropriate placements for CYSHCN and provide training and technical assistance to child care homes and centers to accommodate CYSHCN.

The State School Nurse Consultant provides consultation to school nurses, Missouri School Boards' Association, Missouri Rural Educators Association, Department of Elementary and Secondary Education, and others regarding the development of individualized health care plans for CYSHCN in the school setting.

Two MCH Services district nurse consultants have experience with SHCN and share that expertise with program staff and contractors.

OTHER CAPACITY

Collaboration Capacity

MCH Services staff serve on the Injury Prevention Advisory Committee and Council for Adolescent and School Health and assisted GHC in implementing folic acid education pilots with area high schools utilizing University of Missouri nursing students.

SHCN partners with Missouri Family Voices and University of Missouri Kansas City -- Institute for Human Development (UMKC-IHD) on a grant to establish a Family to Family Health Information Center. The goal of this project is to provide information, training, and personal support to families of CYSHCN.

SHCN partners with UMKC-IHD on a grant for service integration. The goal of this project is to improve and sustain access to quality comprehensive, coordinated community based systems of services for CYSHCN and their families.

SHCN partners with University of Missouri Columbia (UMC) Thompson Center for Autism and Neurodevelopmental Disorders on a grant for Improved Services for Children with Autism Spectrum Disorder and other Developmental Disabilities.

SHCN participates in the Missouri Assistive Technology Council, Missouri Planning Council for Developmental Disabilities, and the Missouri Commission on Autism Spectrum Disorders. The Title V Director serves on the State Interagency Coordinating Council for the IDEA Part C (First Steps) Program.

The State School Nurse Consultant and the School Health Program have active collaborations with the Missouri School Boards' Association, Parents Teacher Organization, the Office of Homeland Security, Safe Schools Task Force, the Farm to School Initiative, the Missouri Association of School Nurses and the Coordinated School Health Coalition.

Culturally Competent Care

Various activities occur across programs on an ongoing basis to address cultural competency. For example:

A one-day Missouri Genetic Conference, "Newborn Screening: What Providers and Parents Need to Know", was held to provide education on the expansion of Missouri's newborn screening

program. Attendees included physicians, dieticians, nurses, genetic counselors, social workers and other health care professionals and also families having a child with a metabolic/genetic disorder or a hearing disorder. Conference topics included an overview of the expanded newborn blood spot screening in Missouri, newborn hearing screening, a closer look at sickle cell disease, cultural competency, transitioning CYSHCN to adult care, setting up parent support groups, and others.

Conference funding was made available through the Heartland Regional Genetics and Newborn Screening Collaborative (HRGNSC). Collaboration occurred between the GHC and SHCN. The SHCN assisted by identifying parents of newborns and children with a condition detected through Missouri's newborn screening program as well as other families having a genetic condition. Scholarships were made available to families to enable them to attend the conference. There were approximately one hundred people attending.

Missouri Newborn Hearing Screening Program (MNHSP) staff and Kansas City MOHear (service coordinator for infants who are deaf or hard-of-hearing) periodically attend cultural competence training including a presentation on the use of health services by refugees in Missouri. The MNHSP provides parent informational brochures in English, Spanish, Bosnian, and Vietnamese. Informational flyers on hearing loss and risk factors for late-onset hearing loss are printed in English and Spanish. Follow-up coordinators (FCs) utilize interpreting services during phone calls to families. FCs have been trained to say, "please wait while I get a translator," in Spanish.

In order to make newborn hearing screening available to Amish and Old Order Mennonite communities, the MNHSP collaborates with two midwives and one nurse practitioner with ties to these communities. The MNHSP loaned portable hearing screening equipment and provided training in use of the equipment. In return, the hearing screeners report results to the MNHSP and tracking and follow-up is initiated as needed.

The Missouri Sickle Cell Anemia Program (MSCAP) provides parent letters and informational brochures in English and Spanish. Contractors are required to have information and education materials available in a variety of culturally competent formats and provide other services, including foreign language translators and interpreters for hearing impaired.

Newborn Health continues to provide Baby Your Baby Health Keepsake Books in English and Spanish. The books include a wide range of topics including prenatal care, breastfeeding, immunizations, and well child checkups. Educational brochures on other critical maternal and child health topics are also available in various languages. These include preconception health care; folic acid to reduce the risk of birth defects; avoidance of alcohol, tobacco and other drugs; safe infant sleep; and postpartum depression.

In September 2009 a conference was held for the Missouri Community-Based Home Visiting, Building Blocks of Missouri (Missouri's Nurse Family Partnership Program), and the Alternatives to Abortion program staff to educate them on cultural competency. The program Recognizing and Bridging Barriers of Difference: Cultural Competence and Delivering Home Visiting Services was presented by Barbara Bogomolov, Manager of Refuge Services, Barnes-Jewish Hospital in St. Louis. This program provided information on the impact cultural difference has on health outcomes and health disparities; identifying the world view and its impact on delivering home based services; and identifying effective bridging of differences common to Missouri including limited literacy, limited health literacy, and limited English proficiency.

The School Health Services program supports speakers on cultural competency at state and regional conference on an annual basis.

Cultural competence training is provided to CCHCs as a skills building opportunity.

The statewide media campaign, Talk with me, to encourage parents to talk with their kids about

sex, abstinence, and other healthy decisions included ads with diverse youth and parents as messengers.

CASH is composed of adolescent and school health experts representing diverse ethnic backgrounds and geographic areas including rural and urban cultures and communities.

In SHCN Service Coordinators (SCs) and SHCN staff members participate in activities and events to increase knowledge and awareness of cultural diversity including the American Indian Council Symposium, Health Care Quality Forum, West Central Multicultural Forum, Cultural Sensitivity Classes, Vietnamese American Community Committee, Kansas City Minority Health Commission, East Regional Alliance on Minority Health, and the St. Louis Black Expo. A cultural sensitivity training was provided for all SHCN SCs and additional staff at the 2009 statewide meeting. SHCN monitors changing demographics and address changing needs with translation of SHCN letters and forms utilized by non-English speaking participants/families. SHCN had multiple forms translated into 8 languages to better serve individuals with limited English proficiency. SHCN monies fund language line services and interpreters for SCs to communicate with individuals with limited English proficiency. The CYSHCNP and the Family Partnership (FP) contracts contain language including cultural competency requirements.

MCH Services staff, in cooperation with the Center for Local Public Health Services, MO Public Health Association, Council for Public Health Nursing, and MO Association of Local Public Health Administrators offer training through conferences and are pursuing developing courses for the online Learning Management System with St. Louis University School of Public Health. MCH staff will be adding specific language and reporting requirements related to serving culturally diverse groups in the FFY2012 contracts.
An attachment is included in this section.

C. Organizational Structure

Organization charts for the State of Missouri, Department of Health and Senior Services and the Division of Community and Public Health are attached to this section.

It is through the executive branch of Missouri's government that the greatest proportions of state services are delivered. The Missouri Constitution provides for 16 specific departments, of which one is the Department of Health and Senior Services (DHSS). Within each executive department exist a variety of offices of varying size and scope which deal with specific services. DHSS services are organized under the Department Directors Office in four Divisions. The Division of Community and Public Health (DCPH) is the largest of the four divisions and provides a majority of the services to the maternal and child populations.

Division of Community and Public Health (DCPH)

DCPH is responsible for supporting and operating more than 100 programs and offices addressing public health issues such as: communicable disease control; chronic disease management; health promotion activities; CYSHCN; genetic health conditions; cancer; pregnancy and pediatric conditions; vital statistics; oral health; health care access; local public health agencies; etc.

DCPH is organized into four Sections with other various Centers and Offices reporting directly to the Division Director's Office. See the attached Organization Structure for a detailed listing of the Sections, Bureaus, and Offices within DCPH.

Included in DCPH is the Section for Healthy Families and Youth (HFY) which is the Title V agency for Missouri and is made of two primary units, the Bureau of Genetics and Healthy Childhood (GHC) and the Bureau of Special Health Care Needs (SHCN).

GHC promotes and protects the health and safety of individuals and families based on their unique conditions, needs and situations, utilizing multiple programs within the bureau. The bureau achieves this by implementing prevention and intervention strategies to optimize health and environment from pre-pregnancy through adulthood. Related activities of the bureau encompass public and professional education; screening and follow-up services; surveillance; needs assessment; and resource identification and/or development. The bureau accomplishes its mission in collaboration with families, health care providers and other community, state and national partners.

SHCN provides statewide health care support services, including service coordination, for children and adults with disabilities, chronic illness and birth defects. Service coordination is essential for people with complex conditions and needs. SHCN administers multiple programs and initiatives including: the Children and Youth with Special Health Care Needs Program (CYSHCNP), Healthy Children and Youth Program (HCY), Physical Disabilities Waiver Program (PDW), Adult Head Injury Program (AHI), Missouri Head Injury Advisory Council (MHIAC), and the Family Partnership. In addition, SHCN participates in a number of other initiatives, including the Missouri Assistive Technology Council, the Planning Council for Developmental Disabilities, and the Missouri Commission on Autism Spectrum Disorders.

Division of Regulation and Licensure (DRL)

The DRL has responsibility for a spectrum of services for Missouri citizens from child care to elder issues, as well as the Family Care Safety Registry, the Board of Nursing Home Administrators, and the Certificate of Need program. Included in DRL is the Section for Child Care Regulation (SCCR) which is responsible for the licensing and regulation of child care facilities in Missouri. The section licenses family child care homes that provide child care for up to ten children; group child care homes for 11-20 children; and, child day care centers of 20 or more children, dependent upon available space, staff qualifications and other requirements that impact children's health and safety. The section regulates license-exempt child care programs. These include child care programs operated by religious organizations and nursery schools.

Division of Administration

The Division of Administration provides fiscal, administrative and general services support to all department units. Services include budgeting, accounting, expenditure control, procurement, grant administration, internal control and procedure review, legislative review and general office support.

Division of Senior and Disability Services

The Division of Senior and Disability Services is the designated State Unit on Aging, carrying out the mandates of the State of Missouri regarding programs and services for seniors.

An attachment is included in this section.

D. Other MCH Capacity

Maternal and Child Health Related Full Time Employees (FTE)

The Division of Community and Public Health employs a total of 740.04 FTE. There are 586.55 FTE located in the Central Office and 153.49 FTE located in other regions across the state. Within the Healthy Families and Youth section, there are 4 Administrative FTE located in the Central Office. Genetics and Healthy Childhood employs 26 FTE within the Central Office, and 3 FTE in other locations across the state. Special Health Care Needs employs 19 FTE within the Central Office and 41 FTE in other locations across the state.

Senior Level Management

Also see the attachment to the preceding section, III. State Overview, C. Organizational Structure.

Glenda R. Miller, RN, MPH, BC CHNCS, became the Director of the Division of Community and Public Health (DCPH) in August 2005; she had previously been Director of the former Division of Maternal, Child and Family Health located in the Department of Health and Senior Services (DHSS). Ms. Miller's diverse background includes serving as: Director of Center for Local Public Health Services where she developed and monitored the Core Public Health Functions contract in 114 counties and evaluated effectiveness and efficiency of the public health system; Education/Training/Social Marketing Coordinator for Burrell Behavioral Health where she developed education and training for System of Care Federal Grant, designed a strategic plan for social marketing and coordinated training and social marketing for multiple agencies in six counties; Project Evaluator, Sinclair School of Nursing for University of Missouri-Columbia; Faculty Instructor for Southwest Missouri State University; Faculty/Instructor for Webster University; Director, Disease Management and Health Risk Assessment for Cox Health Plans; Medicaid Special Programs Manager for Cox Freeman Health Management Services; HIV/AIDS Care Service Coordination (Emergency Appointment) for Missouri Department of Health; Assistant District Administrator for Missouri Department of Health for 21 counties in Southwest Missouri; and Community Health Nurse Consultant for Missouri Department of Health.

Harold Kirbey, BS in Sociology and graduate work at UMC in Rural Sociology, was appointed Deputy Director of DCPH, November 1, 2006. Mr. Kirbey has served DHSS since 1987 in the positions of Health Program Representative, Management Analyst Specialist II, Bureau Chief and Chief of Office of Primary Care and Rural Health. His experience with DHSS, the legislature, LPHAs, primary care providers and other public health partners serve DCPH well.

Kerri Tesreau, MBA, is the Director of Operations for the Division of Community and Public Health. Mrs. Tesreau is primarily responsible for oversight of the Office of Financial and Budget Services (OFABS) and state budget preparation, analysis and tracking for the Division. Additional duties include distribution, coordination, tracking and approval of legislative bill reviews and fiscal notes, preparation of routine and special fiscal reports, and the approval of grants, contracts and expenditures.

Melinda Sanders, MS(N), RN, is the Section Administrator for Healthy Families and Youth (HFY) in DCPH and the Title V Director for Missouri with responsibility for the Title V Block Grant application and statewide MCH need/capacity assessments. She began her work at DHSS in 1998. Ms. Sanders has 31 years of nursing experience, including 12 years as a Family Nurse Practitioner. While at DHSS, Ms. Sanders worked as a Consultant Community Health Nurse for children with special health care needs and Chief of the former Bureau of Genetics and Disabilities Prevention before becoming Section Administrator. Ms. Sanders holds Bachelor and Master of Science degrees in Nursing from the University of Missouri-Columbia.

Cindy Wilkinson, MSW, is the Deputy Section Administrator for DHSS, DCPH, HFY. Ms. Wilkinson is an experienced administrator with expertise in various aspects of children's healthy development, including 25 years with the Children's Division, Department of Social Services working in the area of child protective services. Ms. Wilkinson holds a Bachelor of Science degree in Family and Environmental Resources from Northwest Missouri State University-Maryville and a Masters in Social Work from the UMC.

Epidemiological Capacity

MCH epidemiological capacity is enhanced through an MCH Epidemiology Response Team located in the Section of Epidemiology for Public Health Practice (EPHP), DCPH to focus on maternal and child health related programs and activities. In May 2008, Mei Lin, MD, MSc,

became the CDC MCH Epidemiology Assignee to DHSS from the CDC's MCH Epidemiology Program. Dr. Lin is Co-Leader of MCH Epidemiology Response Team with Public Health Epidemiologist Venkata Garikapaty, PhD, MPH. In FFY10 an additional 2.20 FTE were assigned to work with the MCH Epidemiology Response team.

Parent\Family Initiatives

The Family Partnership (FP) Initiative was formed by SHCN to enhance the relationship between SHCN and the families they serve. The FP Initiative is implemented by SHCN through a contract with a Local Public Health Agency (LPHA) for statewide activities and provides families of individuals with special health care needs an opportunity to: offer each other support and information; give SHCN input; increase public and community awareness of special needs issues; and promote legislation for programs for individuals with special needs and their families. SHCN materials are distributed for FP members' feedback. Four Family Partners, employed by the LPHA, are paid with SHCN monies. Family Partners are chosen for their expertise as parents or caregivers of individuals with special health care needs. Family Partners conduct regional meetings and a statewide conference for family members/caregivers on an annual basis. Approximately 90 to 100 family members participate in these conferences for the exchange of information and mutual education and support. Family Partners conduct outreach activities to encourage participation in FP meetings. SHCN explored and researched interest groups to assist in the identification and recruitment of youth participation.

E. State Agency Coordination

Organization relationships among state agencies are illustrated in the attachment to Section III. C. Organizational Structure.

Department of Social Services (DSS)

DSS is responsible for coordinating programs to provide public assistance to children and their parents, access to health care, child support enforcement assistance and to provide specialized assistance to troubled youth.

The SHCN Service Coordination staff, Building Blocks of Missouri (Missouri's Nurse Family Partnership) Nurse Home Visiting Program, the Missouri Community-Based Home Visiting Program, and the Alternatives to Abortion programs collaborate with other state agencies and local communities to assist in enrolling women, infants and children in Medicaid. Educational materials distributed by these programs provide information about enrolling children in Medicaid.

School Health Services Program provides regional workshops for school nurses and school social workers on enrolling children in Medicaid. Annual updates related to Medicaid enrollment are sent by email to all school health services personnel. The program works with the MO HealthNet Division in DSS to assure schools have applications and outreach materials in multiple languages.

SHCN information system links with the Medicaid Agency to provide Medicaid status and easy access for service coordination services. SHCN also has an agreement with the Disability Determination Unit (DDU) to refer children who apply for SSI to SHCN regional offices.

The Office of Primary Care and Rural Health (OPCRH) has a Memorandum of Understanding (MOU) with DSS to provide partial funding for the Donated Dental Services Program (DDS). DDS improves the quality and availability of oral health services to high risk populations. Through the contract, DHSS has established dental services and laboratory dental fabrication for those with seriously neglected dental problems and no means of paying.

MCH Program Manager with DHSS Center for Emergency Response and Terrorism, Child Care

Regulation, Children's Division, Family Support Division, & Department of Mental Health are initiating statewide planning for children and disasters.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. The Missouri EPSDT program provides all Medicaid eligible children with appropriate full health screens and subsequent treatment for identified health problems. Components of a full health screen include interval history, physical examinations, anticipatory guidance, laboratory tests, immunizations, lead screening, development/personal social/language, fine/gross motor, hearing, vision, and dental. Outreach efforts for the EPSDT occur under a cooperative agreement between DSS and DHSS to include promotion of age appropriate, periodic screenings. As a component of the MCH contracts LPHAs work to enroll children/families in Medicaid and encourage EPSDT.

Managed care programs have made focused efforts on encouraging EPSDT visits with the adolescent and young child populations. Reminder cards were mailed to parents of young children along with periodicity and immunization schedules. Efforts to reach adolescents include: annual Birthday cards with reminders about well child checks; sending providers a list of teens who were due for a wellness check; mailing teen health newsletters, brochures and website information targeted to 12-14 yr olds; newsletters included immunization information and other screening information (STD); and one plan created a Facebook page on the importance of wellness checks in teens.

Department of Elementary and Secondary Education (DESE)

DESE is the administrative arm of the State Board of Education. It is primarily a service agency that works with educators, legislators, government agencies and citizens to maintain a strong public education system. Through its statewide school-improvement activities and regulatory functions, the Department strives to assure all citizens have access to high-quality public education. The Department's responsibilities range from early childhood to adult education services.

The Missouri Newborn Hearing Screening Program (MNHSP) collaborates with the IDEA Part C (First Steps) Program to develop the annual Newborn Hearing Screening Report of aggregate information about children diagnosed with hearing loss and enrolled in First Steps. With parental/guardian permission, First Steps shares the Individual Family Service Plan (IFSP) of children enrolled in early intervention for hearing loss with the MNHSP for data analysis and program development. Additionally, the MNHSP collaborates with First Steps to supplement service coordination for newborns diagnosed with hearing loss using the MOHear Program.

The School Health Services Program (SHS) maintains a database with all public and private school nurses. This database is used to update school health professionals "just in time" with alerts related to food and product recalls, MCH Knowledge Path updates, CDC updates, resource announcements and public health announcements. There are over 1,300 names in the database and it is updated annually. This was a primary communication tool regarding H1N1 this year. This communication tool has promoted communication and increased confidence among our school nurses.

The state school nurse consultant partners with DESE to sponsor new school nurse orientation, coordinated school health conference and the state school nurse annual conference. Guidelines for School Health Services programs are a collaboration among DESE, the State Board of Nursing, and the School Boards' Association.

DESE representatives actively participate on the Coordinating Board for Early Childhood (CBEC) and the Early Childhood Comprehensive Systems (ECCS) Steering Team.

Department of Mental Health (DMH)

The Building Blocks of Missouri (Missouri's Nurse Family Partnership) Nurse Home Visiting Program, the Missouri Community-Based Home Visiting Program, and the Alternatives to Abortion programs refer pregnant women using alcohol and other drugs during pregnancy to the Comprehensive Substance Treatment and Rehabilitation (CSTAR) Program for treatment. Women who screen positive for depression using the Edinburgh Post Partum Depression Screening Tool are referred to their primary care physician or to a mental health provider with the DMH network for further assessment and treatment if necessary.

MCH Services staff participates on state steering committee and provide technical assistance with DMH staff for three pilot sites in Show Me Bright Futures public health model for addressing mental health in children. Collaborative partners are School Health, Department of Elementary and Secondary Education, Children's Trust Fund, MO Student Success Network, Children's Division, Missouri Foundation for Health, and Georgetown University.

SHCN is a partnering agency in the Missouri Autism Rapid Response Initiative, which is a pilot program sponsored by the Department of Mental Health, Division of Developmental Disabilities, designed to improve outcomes for individuals with Autism Spectrum Disorders (ASD) and their families. Parents work with public and private agencies to develop a collaborative, community-based program to enhance early diagnosis and intervention, especially targeting children ages 0-5.

DMH programs that serve youth participate on Council for Adolescent and School Health (CASH). Representatives from DMH also serve on both the CBEC and ECCS Steering Team.

Local Public Health Agencies (LPHAs)

LPHAs in Missouri are autonomous and operate independently of each other and state\federal public health agencies. MCH Services Program is within the Center for Local Public Health Services (CLPHS). CLPHS serves as a liaison between other DHSS programs and LPHAs. Through contracts, LPHAs work directly with DHSS to deliver public health services in each of Missouri's communities. MCH Services contracts with 112 of the 114 LPHAs. Six district nurse consultants provide technical assistance, consultation, and monitoring. MCH contracts with LPHAs require developing community collaborations to build sustainable systems to expand resources to address MCH health issues.

LPHAs partner in injury, obesity and tobacco prevention interventions. Some contractors provide home visiting and case management services. Training is provided to support LPHAs and community efforts. MCH Services district nurse consultant's work with School Health Services to provide technical assistance, resources, and monitoring for school nurse contractors linking them with LPHAs and other community partners. The majority of WIC programs reside in LPHAs.

SHCN maintains contracts with LPHAs to provide service coordination for CYSHCNP and adult survivors of Traumatic Brain Injury and contracts with one LPHA to coordinate the Family Partnership activities statewide.

Adolescent Health Program (AHP) contracts with five LPHAs to implement local Teen Outreach Program (TOP) projects. AHP and the CLPHS provide technical assistance to LPHAs interested in developing teen pregnancy prevention coalitions.

Federally Qualified Health Care Centers (FQHC)

Through the Primary Care Resource Initiative for Missouri (PRIMO) the Office of Primary Care and Rural Health (OPCRH) is able to allocate funds to safety net providers, such as Federally Qualified Health Centers (FQHC) to implement and sustain primary medical, behavioral, and dental care to uninsured and underinsured populations.

Missouri has 21 FQHC - Community Health Centers (CHCs) with numerous satellite sites throughout the state. Per the HRSA website, there are more than 140 distinct CHC sites operating in Missouri. The Federally Funded CHCs provided primary care, oral health, and\or behavioral health services to over 350,000 individuals in 2008. CHCs are present in every region of the state and serve residents of 111 counties plus the City of St. Louis.

Additionally, the OPCRH conducts the Health Professional Shortage Areas (HPSA) survey to determine which counties are eligible to be recommended to HRSA. The survey process takes into account population and provider demographics to determine if access to care is available for all populations.

Tertiary Care Centers

There are four university-affiliated genetic tertiary center contracts to support the statewide newborn screening program. The centers provide evaluation for genetic conditions, genetic screening, counseling, and outreach along with tracking and follow-up on all abnormal newborn screen results. Consultation is given to health care providers on those disorders screened by the newborn screening program. Infants found positive for a newborn screened condition are offered medical, nutritional, and genetic counseling services and are followed to ensure that they are entered into a system of health care.

DHSS contracts with five hospital resource centers to ensure the availability of comprehensive medical services for individuals diagnosed with sickle cell disease. Infants identified with sickle cell disease are referred to the resource centers for follow-up to ensure that all infants receive confirmatory testing and that appropriate treatment is initiated. This early diagnosis and treatment have been significant in helping children with sickle cell disease live longer and healthier lives. Other services provided by these centers include: annual physical examinations, follow-up for both medical and non-medical needs, public and professional education to increase awareness of the target population, screening for detection of sickle cell conditions, and genetic counseling to individuals and families identified with sickle cell and other hemoglobin traits.

Missouri Kids First contracts to coordinate three hospital resource centers to provide education, training, and support to physicians and nurse practitioners who conduct medical evaluations of alleged victims of child maltreatment.

SHCN has approximately 380 provider contracts. Through provider agreements with tertiary care centers, pre-approved specialty and sub-specialty care is provided for CYSHCN who otherwise would have no resources for health care services.

Universities

The Missouri Newborn Hearing Screening Program (MNHSP) collaborated with Missouri State University (MSU) to design and implement the MOHear Program consisting of: 1) service coordination for families of newborns diagnosed with severe to profound permanent hearing loss and 2) hearing rescreening for infants who failed or missed the initial hearing screening. Service coordinators are professionals with backgrounds in audiology, speech and language therapy and/or deaf education. Since 2007, one service coordinator has worked in the Kansas City region. She accompanies First Steps service coordinators to the homes of newborns diagnosed with permanent severe to profound hearing loss, provides unbiased information about communication options, and facilitates the majority of the service coordination. Following the receipt of supplemental funding from HRSA, the MNHSP contracted with MSU in 2009 to expand the program by hiring four additional service coordinators and expand their roles to include follow-up hearing screenings for newborns that fail their initial hearing screening and have no documentation of rescreening or audiologic evaluation. The service coordinators will use portable hearing screening equipment and meet families in their homes or other convenient locations.

SHCN partners with University of Missouri Kansas City (UMKC), the grantee for the Missouri Family to Family Health Information and Education Center Grant and the Missouri Partnership for Integrated Community Services for CYSHCN Grant. SHCN is represented on the leadership council of both grants.

SHCN partners with The Thompson Center at University of Missouri-Columbia, the grantee for the State Improvement Grant for Improved Services for Children with Autism Spectrum Disorder and other Developmental Disabilities Grant. SHCN is represented on the leadership council of the grant.

Service Coordinators with SHCN participate in the University of Missouri LEND (Leadership Education in Neurodevelopmental and Related Disabilities) Program trainings and staff provide training at least once annually for the LEND group.

SHCN contracts with the University of Missouri Kansas City - Institute for Human Development (UMKC-IHD) and the University of Missouri Columbia (UMC) to implement activities of the Traumatic Brain Injury Implementation Partnership Grant.

Adolescent Health Program (AHP) and Council for Adolescent and School Health (CASH) is collaborating with the University of Minnesota (Konopka Institute for Best Practices in Adolescent Health) to develop Understanding Adolescence workforce development training module for MCH programs, contractors, state agencies, and other youth-serving organizations.

Center for Local Public Health Services (CLPHS) and Genetic and Healthy Childhood staff participated on state steering committee with University of Missouri School of Nursing, Domestic and Sexual Violence coalitions and Robert Wood Johnson Foundation to develop intimate partner violence screening tool and coordinate training for pilot communities involving college campuses, LPHAs, and Whiteman Air Force Base.

The Injury and Violence Prevention Program has contracted with the University of Missouri, Think First Program to provide education to middle and high school students regarding head and spinal cord injuries.

Boards, Committees, and Councils

DHSS, Healthy Families and Youth (HFY) is represented on the State Interagency Coordinating Council (SICC) which advises and assists the Department of Elementary and Secondary Education (DESE) in the performance of responsibilities as stated in the Individuals with Disabilities Education Act (IDEA) Part C Program for infants and toddlers with disabilities.

HFY staff represents DHSS on the Missouri Special Quest State Leadership Team. This team, coordinated by the State Head Start Collaborative Office, has a goal to develop plans and strategies to increase inclusive opportunities for children with special needs from birth to five in early care settings.

Comprehensive System Management Team (CSMT) is responsible for the development of the children's comprehensive mental health plan for the state and the HFY Deputy Section Administrator participates on the team.

Adolescent Health Program (AHP) coordinates the statewide Council for Adolescent and School Health (CASH) and the council advises DHSS in assessing adolescent health needs and planning effective strategies to reduce health risks and promote healthy youth development. AHP is represented on school dropout prevention advisory groups. AHP Coordinator serves on the Governor's Substance Abuse Prevention Advisory Committee and the Missouri Youth/Adult Alliance.

The Title V Director is on the Thompson Center for Autism and Neurolodevelopmental Disorders Advisory Board and the Kansas City Healthy Start grantee, Mother and Child Health Coalition Advisory Committee.

In January 2007, the Governor appointed the first Missouri Coordinating Board for Early Childhood (CBEC). DHSS is represented on the Board and the membership of the CBEC has substantial expertise in early childhood systems; many are recognized and active at the national level and are key sources of information and networking regarding developing policy issues.

DHSS and DESE jointly participate on the State Reconvene Team with National Stakeholders Collaborative to Integrate HIV, STD, and Teen Pregnancy Prevention for School-aged Youth and the Preconception Health for Adolescents Action Learning Collaborative (ALC) to increase collaboration among state public health and education agencies on implementing evidence-based approaches to HIV, STD, and teen pregnancy prevention and preconception health for adolescents.

The Injury and Violence Prevention Program coordinates the Missouri Injury and Violence Prevention Advisory Committee to address injury issues and provide guidance on injury prevention initiatives and activities. The committee is comprised of state and local public and private professionals.

The Adult Head Injury (AHI) Program, in the Bureau of Special Health Care Needs, facilitates the Missouri Head Injury Advisory Council (MHIAC). MHIAC is comprised of members, appointed by the Governor and the Missouri General Assembly, to represent consumers, families with a member with head injury, professionals, proprietary schools, private industry, health industry, and state agencies which administer programs regarding education, mental health, health, Medicaid, insurance, and public safety. MHIAC is advisory to DHSS and also serves in a specific advisory capacity to the Traumatic Brain Injury Implementation Partnership Grant.

The ECCS Project Director is a member of the American Academy of Pediatric Dentistry (AAPD) Head Start Dental Home Initiative (DHI) state leadership team. This partnership will help children access oral health care through the development of a national network of pediatric and general dentists who will provide quality dental homes for Head Start and Early Head Start children.

Bureau for Health Informatics (BHI) and the Title V Director actively participate on the Missouri Medicaid Managed Care Quality Assessment and Improvement Advisory Committee and BHI provides data on birth indicators to assist in evaluating and improving the health of mothers and children using Medicaid.

Grants and Other Collaborations

The Missouri Newborn Hearing Screening Program (MNHSP) receives funding from the CDC to establish an electronic data management system that will link to bloodspot newborn screening and vital records. The MNHSP data management system is part of the Missouri Health Strategic Architectures and Information Cooperative (MOHSAIC) a larger, integrated system that incorporates many DHSS programs. Currently, MOHSAIC provides the MNHSP with data entry capabilities for hearing screening results, case management, and statistical reports. The MNHSP also receives funding from HRSA for reducing loss to follow-up following failure to pass the initial hearing screening.

The MNBSP collaborates with the Missouri Genetic Advisory Committee, the Heartland Regional Genetics and Newborn Screening Collaborative, and the National Newborn Screening and Genetics Resource Center. The purpose of collaboration is to enhance, improve, or expand the ability of MNBSP to provide quality health care to newborns and children at risk for heritable disorders. Collaboration with Heartland has consisted of: collecting information on transfusion

practices in hospitals and blood banks; developing family emergency preparedness plans; and reviewing states' newborn blood spot screening reports to look for areas of improvement and harmonization of basic information.

Missouri was one of six states selected to participate in the Preconception Health for Adolescents Action Learning Collaborative (ALC) initiative with AMCHP, ASTHO, CDC, and fellow innovative states on integrating preconception health recommendations into adolescent health efforts. Missouri Team members included: DHSS' Adolescent Health Program, Office of Women's Health, and other programs; DESE Family and Consumer Sciences Education programs; Missouri Foundation for Health; and various stakeholders.

The Section for Healthy Families and Youth collaborates with the Maternal, Child and Family Health Coalition of St. Louis, the Mother and Child Coalition of Greater Kansas City, and the Missouri Bootheel Regional Consortium to implement programs and discuss issues related to the MCH population in their areas. Face to face meetings are held annually and conference calls three to four times a year in order to facilitate these efforts.

CLPHS provided training/best practices for contractors on injury, obesity & tobacco prevention with University of MO Extension (nutrition), Children's Trust Fund, Missouri KidsFirst, SAFE Kids Coalitions and Comprehensive Tobacco Program. Staff participates in a planning committee led by the Missouri Bicycle & Pedestrian Federation on Safe Routes to Schools.

The Missouri Chapter American Academy of Pediatrics partners with DHSS to provide training and education on current adolescent health issues, immunizations, breastfeeding, and newborn health.

The Missouri American Academy of Pediatrics Early Hearing Detection and Intervention (EHDI) Chapter Champion supports the Missouri EHDI system by educating pediatricians and families on the importance of newborn hearing screening and appropriate follow-up.

Bureau for Health Informatics (BHI) assists the St. Louis University School of Public Health in sponsoring the ongoing development and training of an Evidence Based Public Health Decision Making course that emphasizes using documented data and intervention results to assist in health planning. This course is offered to DHSS and LPHA employees.

F. Health Systems Capacity Indicators

Introduction

While the majority of activities listed below are funded in some portion (staffing, supplies, etc.) by the MCH Title V Block Grant, there may be some which do not receive funding from the Block Grant but still impact the health systems capacity indicator.

Bureau of Health Informatics (BHI) is the primary source for health data within the state. BHI oversees the statistical support and health care monitoring activities of DHSS; collects, analyzes and distributes health-related information which promotes better understanding of health problems and needs in Missouri; and highlights improvements and progress achieved in the general health status of Missourians. MCH-related data files created and maintained by BHI include the Patient Abstract System (PAS), birth defects registry, induced termination of pregnancies, live births, fetal deaths, maternally-linked births, multiple-birth file, linked birth-PAS File, linked birth-Medicaid file, and the linked motor vehicle crash records-PAS file.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	34.6	36.4	31.6	35.2	35.2
Numerator	1326	1406	1245	1406	1406
Denominator	383096	386752	393940	399450	399450
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Source: Numerator is from DHSS patient abstract system, inpatient hospitalization data. 2008 data used as proxy for 2009. 2009 Final hospital discharge information will be available April 2011.

Population estimate for 2008 is used as proxy for 2009 denominator, obtained from Missouri Information for Community Assessment (MICA)-Population. Final population information available November 2010.

Notes - 2008
Source: Numerator is from DHSS patient abstract system, inpatient hospitalization data. Provisional 2007 used as proxy for 2008. Final hospital discharge information & 2008 population will be available November 2009.

Population estimate for 2007 is used as proxy for 2008 denominator, obtained from Missouri Information for Community Assessment (MICA)-Population.

Notes - 2007
Source: Missouri Information for Community Assessment (MICA) - Inpatient Hospitalization, and the Bureau of Health Informatics, MO DHSS. 2007 data will be available in December 2008, and 2006 data are used as proxy for 2007.

Narrative:
Based on the most recent air quality data, the U.S. Environmental Protection Agency has determined that all areas in Missouri meet the National Ambient Air Quality Standards for fine particles, measured over a 24-hour period. Meeting these air-quality standards is very important to protect public health, because when inhaled the fine-particle pollution can aggravate asthma as well as other chronic lung problems.

The Early Childhood Asthma Initiative in Missouri (ECAIM) is a DHSS initiative through ARRA funding which is making progress in improving the quality of childcare facilities in identifying and reducing asthma triggers. In addition, the program is improving the care of children in these facilities through asthma management education for families of these children. Progress to date includes: 1) Contracts developed for approximately 60% of the Local Public Health Agencies for either environmental assessment for childcare facilities to identify and reduce asthma triggers, and/or provision of childcare consultation services to families of children with asthma, and/or strategy development for linking childcare facilities to local, state, and national resources to address asthma; 2) On-line asthma education for childcare consultants; 3) Training for environmental specialist to provide childcare environmental assessments; and 4) Development of educational materials for childcare facilities on asthma trigger identification and reduction, management of asthma in the childcare setting, and families of children with asthma on home asthma trigger identification and reduction and asthma management.

The care of CYSHCN in child care is a targeted health issue for intervention from the Child Care Health Consultation (CCHC) program. Care of children with asthma is the focus of most of that effort with the goal being to reduce emergency room visits and hospitalizations for young children with asthma. In FFY 2009 the CCHC provided 132 hours of group education about the Management of Asthma in Young Children to 913 child care providers and 25 young parents. In addition, 63 hours of group education on Environmental Triggers in Child Care Centers (Indoor Air Quality) was provided to 548 child care providers and 17 parents. A total of 42 child care providers received one on one consultation regarding asthma management and 18 asthma action plans were put in place.

Service coordination is available through the Children and Youth with Special Health Care Needs Program (CYSHCNP) to assist children with asthma in obtaining necessary services.

The School Health Services Contract has a performance measure related to case management of a child with a special health care need or a chronic condition. Establishment of an Asthma Action plan is one component of this. These contracts reach both the preschool and school age populations.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	91.9	92.8	90.8	90.7	91.3
Numerator	34465	40497	40857	41175	40776
Denominator	37488	43619	44982	45389	44674
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Source: Division of Medical Services, MO HealthNet, Department of Social Services. Numerator is number of Medicaid enrollees (including SCHIP) age less than one year in FFY 2009 who received at least 1 periodic screen. Denominator is number of Medicaid enrollees (including SCHIP) whose age is less than one year in FFY 2009.

Notes - 2008
Source: Division of Medical Services, MO HealthNet, Department of Social Services. Numerator is number of MO HealthNet (Medicaid) enrollees (including SCHIP) age less than one year in FFY 2008 who received at least 1 periodic screen. Denominator is number of MO HealthNet enrollees (including SCHIP) whose age is less than one year in FFY 2008.

Notes - 2007
Source: MO HealthNet Division, Missouri Department of Social Services.

Numerator is the number of Medicaid enrollees (including SCHIP) whose age is less than one year in FFY 2007 who received at least one initial or periodic screen. Denominator is the number of Medicaid enrollees (including SCHIP) whose age is less than one year in FFY 2007.

Narrative:
The Building Blocks of Missouri (Missouri's Nurse Family Partnership) Nurse Home Visiting Program, the Missouri Community-Based Home Visiting Program, and the Alternatives to Abortion programs ensure all women enrolled in their programs are educated about keeping appointments with their health care providers. There were 815 families served in the Community-Based Home Visiting Program, 446 families in serviced in the Building Blocks program, and 2,641 women served in Alternatives to Abortions.

The Baby Your Baby website (http://www.dhss.mo.gov/babyyourbaby) and Baby Your Baby Health Keepsake Books provide information to women about healthy babies, including information about the importance of early and periodic screening. In 2009, 30,483 Baby Your Baby Keepsake Books in English and 1,924 books in Spanish were distributed statewide to Local Public Health Agencies, WIC, hospitals, health care providers, Community Health Centers (FQHCs), Parents as Teachers, Early Head Start, insurance providers, and primary care facilities.

Special Health Care Needs (SHCN) Programs collaborate with other state agencies and local communities to identify and help enroll children in Medicaid. The Children and Youth with Special Health Care Needs Program (CYSHCNP) Program and the Healthy Children and Youth (HCY) Program provide service coordination for children from birth to age 21. Service coordination includes providing resources to obtain necessary services, including periodic screenings.

Child Care Health Consultants (CCHC) program distributes information and provides education to child care providers and parents of young children regarding the availability of health insurance, primary and specialty care services.

Outreach efforts for the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program occur under a cooperative agreement between DSS and DHSS to include promotion of age appropriate, periodic screenings.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	91.9	92.8	90.8	90.8	91.0
Numerator	4879	582	433	442	537
Denominator	5307	627	477	487	590
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Source: MO HealthNet Division, Department of Social Services. Denominator is final 2009 number of SCHIP enrollees <1 year of age in FFY 2009. Numerator is SCHIP enrollees under one year who received at least one periodic screen in FFY 2009.

Notes - 2008
Source: MO HealthNet Division, Department of Social Services. Revised in 2006 to reflect more accurate percentage. Denominator is final 2008 number of SCHIP enrollees <1 year of age in FFY 2008. MO HealthNet tracks only total (MO HealthNet clients plus SCHIP) EPSDT numbers but does not track SCHIP EPSDT numbers for this age group. Numerator estimate is

multiplication of the number of MO HealthNet (including SCHIP) enrollees <1 year who received at least 1 screen (41,175) from HSI #2 by the percent of SCHIP enrollees under 1 year (487/45,389=0.0107, FFY 2008).

Notes - 2007
Source: MO HealthNet Division, Missouri Department of Social Services.

The method to determine denominator and numerator for this measure was revised to reflect more accurate information on SCHIP. The denominator is the number of SCHIP enrollees less than one year of age in FFY 2007. MO HealthNet only tracks total HealthNet (Medicaid including SCHIP) EPSDT numbers for children under one year of age, but does not track SCHIP EPSDT numbers for this age group. Therefore, the numerator is estimated by multiplying the number of Medicaid (including SCHIP) enrollees under one year of age who received at least one initial periodic screen (40,857 in FFY 2007, HSCI #2) by the proportion of SCHIP enrollees under one year of age among the total number of Medicaid (including SCHIP) enrollees under one year of age (477 / 44,982 = 0.0106, FFY 2007).

2006 denominator and numerator were also changed based on the revised method.

Narrative:
Refer to Health Systems Capacity Indicator 02. Programs and activities used to encourage proper screenings and to make Medicaid availability known are used for the SCHIP program as well.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	79.2	77.2	75.2	74.3	75.5
Numerator	62177	62764	61545	60141	59366
Denominator	78547	81353	81883	80944	78631
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Source: Birth Data, DHSS Vital Statistics. 2009 provisional data as of April 2010. Final birth information will be available November 2010.

Numbers for 2008 are updated with 2008 final data.

Similar to the pattern observed for early prenatal care (PNC) in MO, the percentage of adequate PNC based on the Kotelchuck Index slighly increased in 2009 (provisional) compared with the figure in 2008.

Notes - 2008
Source: Birth Data, DHSS Vital Statistics. 2008 provisional data as of April 2009. Final birth information will be available October 2009.

MO experienced a slight but noticeable decline in this measure in the past three years 2006-08. The decline was slightly larger for the Medicaid population than for the non-Medicaid population. This decline is attributable to a lack of OB health care providers, especially in the southeast segment of the state and those willing to serve the Medicaid population. In addition, it appears that OB providers utilizing a software program for prenatal visits are transferring records to the anticipated birth hospitals earlier in the pregnancy (i.e.: 36 weeks) and fail to send subsequent visits giving the appearance an inadequate number of prenatal visits occurred. Adequate prenatal care (PNC) followed the similar pattern observed for early PNC. MO will continue to investigate the effect of this practice.

As explained for the National Performance Measure #18 - early PNC, more recent changes to welfare and Medicaid policy might limit further improvements in adequate PNC. Change in reporting system might also be a factor.

Notes - 2007
Source: Missouri Information for Community Assessment (MICA) - Births and the Bureau of Health Informatics, MO DHSS. 2007 provisional data as of April 28, 2008. 2007 final birth data will be available in October 2008.

Narrative:
The Missouri Community-Based Home Visiting, Nurse Family Partnership (Building Blocks of Missouri) Home Visiting, and Alternatives to Abortion programs educate their clients on the importance of early entry into and adequacy of prenatal care. Clients are assisted with finding a prenatal care provider if they do not have one when enrolling in the program and on applying for Medicaid\SCHIP to have a payment source for prenatal care. Home visiting staff continually work with their clients to assure they have made and keep follow-up appointments with their prenatal care providers to assure adequacy of prenatal care. The Alternatives to Abortion providers work with their clients to assure they have transportation and provide bus passes and gas cards.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	80.0	79.7	79.2	79.1	80.3
Numerator	356000	358000	361000	412000	354000
Denominator	445000	449000	456000	521000	441000
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Accurate number of potentially Medicaid-eligible children is not available. Estimates of denominator and numerator are obtained from 2009 Current Population Survey Table Creator on the US Census Bureau website: http://www.census.gov/hhes/www/cpstc/cps_table_creator

Numerator = Number of kids ages 0-17, below 300% FPL, and on Medicaid.
Denominator = Number of kids ages 0-17, below 300% FPL, and on Medicaid + Number of kids

of ages 0-17, below 300% FPL, and not on Medicaid (uninsured).
Current Population Survey in 2009 represents 2008 data.

Notes - 2008
Accurate number of potentially MO HealthNet (Medicaid) eligible children is not available. Estimate of denominator and numerator are from US Census, Current Population Survey, Annual Social & Economic Supplement, 2008. Source: http://www.census.gov/cgi-bin/broker.

Numerator is children age 17 years and under below 300% of FPL with MO HealthNet coverage. Denominator is number of children age 0-17, below 300% FPL with MO HealthNet coverage plus children age 0-17, below 300% FPL and not covered by Mo HealthNet (uninsured).

Notes - 2007
Accurate number of potentially Medicaid-eligible children is not available. Estimates of denominator and numerator are obtained from Current Population Survey Table Creator on the Census Bureau website: http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

Numerator = Number of kids of ages 0-17, below 300% FPL, and on Medicaid.
Denominator = Number of kids of ages 0-17, below 300% FPL, and on Medicaid + Number of kids of ages 0-17, below 300% FPL, and not on Medicaid (uninsured).

Narrative:
Collaboration among Special Health Care Needs (SHCN) Programs, other state agencies and local communities help to identify and enroll children in Missouri's SCHIP and Medicaid. Service coordination within Children and Youth with Special Health Care Needs Program (CYSHCNP) and Healthy Children and Youth (HCY) assists families in obtaining necessary services for children from birth to age 21, including navigation of the Medicaid system.

Child Care Health Consultants (CCHC) program distributes information and provides education to child care providers and parents of young children regarding the availability of Medicaid.

The Child Care Resource and Referral Network (CCRR) provide statewide services for families and CYSHCN needs through eight local agencies. Qualified inclusion staff are located in each CCRR agency to provide statewide-enhanced services. All eight local agencies maintain toll-free phone numbers. Families may call and seek referrals to child care programs. Referral Specialists collect data such as: immunization status of children, health issues including diseases and birth defects, developmental issues, and insurance status of children. Inclusion staff assist with development of a plan of action, in collaboration with the family, to support child care services to CYSHCN; provide coordination services to accommodate CYSHCN by working with families, child care homes and centers, and other agencies serving the child; and referral of all families of CYSHCN to the IDEA Part C (First Steps) Program, local Public School District or other appropriate programs or services.

Medicaid Managed Care programs focused on young child and adolescent health Performance Improvement Projects to increase EPSDT screens. The number of EPSDT well child/youth screenings rose from 33% in 2006 to 35.9% in 2009.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	33.7	35.0	38.3	37.5	41.3
Numerator	43175	45850	47818	47298	54115

Denominator	128262	131054	124885	126014	130996
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Source: MO HealthNet Division, Department of Social Services. Numerator is the number of EPSDT eligible children age 6-9 years receiving any dental services in FFY 2009. Denominator is the number of children age 6-9 years eligible for EPSDT in FFY 2009.

Notes - 2008
Source: MO HealthNet Division, Department of Social Services. Numerator is the number of EPSDT eligible children age 6-9 years receiving any dental services in FFY 2008. Denominator is the number of children age 6-9 years eligible for EPSDT in FFY 2008.

MO experienced a decline in this measure as compared to 2007, yet the rate remains higher than 2004 through 2006. It is anticipated this rate will continue to rise in the future based on the fact Medicaid requires all of their Managed Care Plans to conduct a performance improvement project on improving this rate for all children enrolled.

Notes - 2007
Source: MO HealthNet Division, Missouri Department of Social Services.
Numerator is the number of EPSDT eligible children aged 6-9 years receiving any dental services in FFY 2007. Denominator is the number of children aged 6-9 years eligible for EPSDT in FFY 2007.

Narrative:
Through the School Health Services Contracts from 1995 to present the percent of children with a dental exam within the past 12 months increased from 16% to 66%.

Oral Health Program collaborates with many partners to integrate the Preventative Services Program (PSP) into new communities. With the 2009-2010 school year yet to be completed, over 49,000 children have already received an open mouth screening, fluoride varnish application, and oral health education.

Local Child Care Resource and Referral staff provide oral health training to child care providers as part of Basic Child Care Orientation Training supported by DHSS and DSS.

Medicaid Managed Care programs also focused on a dental care Performance Improvement Project which included: providing a separate dental handbook for members, "Floating" Dentists (dentists rotate thru rural sites), partnering with Community Events to promote the importance of dental care, collaborate with schools and School Nurses, encourage dentists to have weekend and evening hours for appointments, providing mobile dental services, Dental Prescriptions (PCP hands the parent/teen a prescription for a dental exam which has information numbers about where to call to make appointments), incentives used to get children and adolescents to exams, public relations campaigns for outreach, "Give Kids A Smile" program at the Dental School in KC or partner with the MO Dental Association, paying higher reimbursement rates for dentists who see a certain number of members within a certain period of time, paying higher rates for Pediatric Dentists, and reminder calls to members who have not had a dental claim submitted on them in the last 6 months.

Both the MCH contracts with LPHAs and School Health Services contracts refer eligible children without health insurance to Medicaid.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	73.6	84.4	81.4	81.6	84.0
Numerator	14308	14434	14421	14668	15588
Denominator	19451	17109	17727	17979	18549
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Denominator is number of Missouri SSI recipients under age 16 years as of December 2009. Source: Social Security Administration Supplemental Security Record. http://www.hrtw.org/youth/data
Numerator is the number of Missouri Medicaid enrollees referred for SSI supported rehab services as of December 2009 under age 16.

Notes - 2008
Denominator is number of Missouri SSI recipients under age 16 years as of December 2008. Source: Social Security Administration Supplemental Security Record. http://www.hrtw.org/youth/data/html.#ssi
Numerator is the number of Missouri MO HealthNet enrollees referred for SSI supported rehab services as of December 2008 under age 16.

Notes - 2007
Denominator is the number of SSI recipients under 16 years old in Missouri, December 2007. Source: Social Security Administration, Supplemental Security Record, available at http://www.hrtw.org/youth/data.html#ssi
Numerator is the number of Missouri Medicaid recipients <16 years of age who are referred for SSI supported rehabilitative services as of December 31, 2007. Source: Missouri Department of Social Services, Research and Evaluation Unit.
Annual indicator for 2006 was revised based on the denominator the number of SSI recipients under 16 years old in Missouri, December 2006. Source: Social Security Administration, Supplemental Security Record. The indicator 2005 and earlier was based on the denominator for ages under 18 years. Therefore the percents for 2007 and 2006 are not comparable with those for 2005 and earlier.

Narrative:
Collaboration among Special Health Care Needs (SHCN) Programs, other state agencies and local communities help to identify and enroll children in Missouri's SCHIP and Medicaid.

The Children and Youth with Special Health Care Needs Program (CYSHCNP) and the Healthy Children and Youth (HCY) Program provide service coordination for children from birth to age 21.

Service coordination assists families in obtaining necessary services, including referrals to SSI.

SHCN has an agreement with the Disability Determination Unit (DDU) to refer children who apply for SSI to SHCN regional offices.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2009	payment source from birth certificate	9.6	6.6	8.1

Notes - 2011
Source: DHSS Vital Statistics. Provisional 2009 birth data as of May 2010. Final numbers will be available November 2010.

Narrative:
The Building Blocks of Missouri (Missouri's Nurse Family Partnership) Nurse Home Visiting Program, the Missouri Community-Based Home Visiting Program, and the Alternatives to Abortion program provide education to pregnant women on tobacco use preconceptually and throughout pregnancy to decrease the incidence of preterm births; need for adequate prenatal care, and birth spacing less than 18 months apart to decrease the incidence of preterm births.

Medicaid Managed Care programs focus on a variety of Performance Improvement Projects which includes hi-risk OB care. This has been a focus for all plans on an on-going basis. Activities include case management, peer to peer educational baby showers, and specialty care (such as gestational diabetes, history of premature labor, pregnancies to those age 17 and under).

Missouri is working as an outreach partner with the text4baby campaign, which provides free educational text messages to encourage healthy behaviors.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2009	matching data files	8.6	5.1	7.1

Notes - 2011
Source: DHSS Vital Statistics. Provisional 2009 birth data as of May 2010. Final numbers will be available November 2010.

Narrative:

In January 2010, the Section for Healthy Families and Youth convened the Infant Mortality Task Force to examine current activities forced on infant mortality and look for ways to collaborate on reducing infant mortality in Missouri. Currently, the task force is comprised of representatives from the Section for Healthy Families and Youth; Bureau of Genetics and Healthy Childhood (GHC); Office of Minority Health (OMH); Office on Women's Health; Office Primary Care and Rural Health; Bureau of HIV, STD, and Hepatitis; and the Office of Epidemiology.

The Building Blocks of Missouri (Missouri's Nurse Family Partnership) Nurse Home Visiting Program, the Missouri Community-Based Home Visiting Program, and the Alternatives to Abortion program provide education to pregnant and parenting women on the importance of providing a safe sleep environment for their infants.

The GHC has contracts with the Maternal, Child and Family Health Coalitions of St. Louis and Greater Kansas City to implement a Fetal and Infant Mortality Program based on the national model establish through the American College of Obstetrics and Gynecology.

A Public Health Consultant Nurse from the GHC and Local Public Health Agencies (LPHAs) serve as members of the State Child Fatality Review team. The team meets at least two times per year to review data concerning deaths of children from the age of one week to 18 years of age. Prevention efforts are then targeted based on the trends shown through the review process.

Beginning April 2010, GHC will provide portable cribs and safe sleep education delivered through LPHAs to decrease the number of deaths to infants related to unsafe sleep practices including bed-sharing. The cribs will be provided to free of cost to low income families.

In FFY 2009, the Child Care Health Consultants (CCHC) program provided 24 hours of education on safe sleep, 220 hours of injury prevention education/consultation, and 560 hours of First Aid/CPR training for child care providers.

The OMH is working with the City of St. Louis Department of Health, St. Louis Maternal Child and Family Health Coalition, Nurses for Newborns, Federally Qualified Health Centers (FQHCs), St. Louis University, Service Corps Volunteers, SIDS Resources, and several of the Medicaid Managed Care programs. The goal of the collaborative is to develop and implement an infant mortality outreach initiative to reduce of infant mortality. These organizations are focused on infant mortality prevention and have established relationships with minority service entities that are also focused on decreasing the infant death rates in minority communities in the St. Louis area. The Prenatal Care and Infant Wellness Collaborative has decided to contract to develop a health education campaign for the 63120 zip code area. The campaign will include focus groups, community outreach, community education, community interventions, and scientific evaluations of the interventions.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2009	payment source from birth certificate	77.7	91.3	84.2

Notes - 2011
Source: DHSS Vital Statistics. Provisional 2009 birth data as of May 2010. Final numbers will be available November 2010.

Narrative:
The Building Blocks of Missouri (Missouri's Nurse Family Partnership) Nurse Home Visiting Program, the Missouri Community-Based Home Visiting Program, and the Alternatives to Abortion programs assure all women enrolled in their programs are getting prenatal care. Since clients can enroll in these programs up to 28 weeks gestation sometimes they are past the first trimester when enrolling. Data is collected on all women enrolled in the programs on entry into prenatal care.

TEL-LINK, the toll-free information and referral line for MCH services, connects pregnant women to prenatal referrals and other services such as Medicaid and WIC. The TEL-LINK website links with the Baby Your Baby website.

The TEL-LINK program collaborates with WIC and Nutrition Services by listing the TEL-LINK number on WIC posters throughout the state for women to call. Promotion of the TEL-LINK program is done through exhibits at various health fairs and conferences, advertising in parenting and health magazines, mailing of the TEL-LINK brochure to Missouri families, state and public agencies, and collaboration with other maternal and child health programs.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2009	payment source from birth certificate	68.9	82.5	75.5

Notes - 2011
Source: DHSS Vital Statistics. Provisional 2009 birth data as of May 2010. Final numbers will be available November 2010.

Narrative:
The Building Blocks of Missouri (Missouri's Nurse Family Partnership) Nurse Home Visiting Program, the Missouri Community-Based Home Visiting Program, and the Alternatives to Abortion programs educate all women enrolled in their programs on the importance of getting prenatal care and keeping their appointments.

The Medicaid Managed Care plans reach this population and provide specific interventions such as case management.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2009	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2009	300

Narrative:
The Medicaid program in Missouri provides health insurance coverage for children under age 1 whose net family income does not exceed: 185% of Federal Poverty Level (FPL). Under SCHIP that coverage is expanded 300% of FPL. The SCHIP program provides the same health services as those covered under Medicaid, except that SCHIP children and youth are not eligible for non-emergency medical transportation. Based on an income scale, some individuals covered under Missouri's SCHIP program must pay premiums. Premiums paid per family per month range from $12 to $300.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2009	 133 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2009	 300 300

Narrative:
The Medicaid program in Missouri provides health insurance coverage for children whose net family income does not exceed: 133% of Federal Poverty Level (FPL) for children ages 1 to 5 and 100% of FPL for youth ages 6 to 18. Under SCHIP that coverage is expanded 300% of FPL. The same limitations and premium levels apply as stated in Health Systems Capacity Indicator 06A.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**

pregnant women.		
Pregnant Women	2009	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2009	185

Narrative:
Pregnant women with family incomes up to 185 percent of Federal Poverty Level (FPL) qualify for Medicaid coverage under the MO HealthNet for Pregnant Women (MPW) program. Qualification under this category includes 60-day postpartum coverage even with subsequent increases in family income.

TEL-LINK, the toll-free information and referral line, for maternal and child health services, connects Missourians to a wide range of services including Medicaid.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	No
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	No
Annual linkage of birth certificates and WIC eligibility files	2	No
Annual linkage of birth certificates and newborn screening files	2	No
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	No
Annual birth defects surveillance system	2	No
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2011

Narrative:
Bureau of Health Informatics (BHI) is responsible for vital statistics system; maintains various health-related databases; performs linkages between program and vital statistics data; provides program evaluations based on applicable program-vital statistics data; collaborates with such entities as MO HealthNet regarding MCH indicators for Medicaid managed-care population; provides support for Missouri Child Fatality Review program; produces health indicators from linked birth-PAS data systems; links Statewide Traffic Accident Records Systems (STARS) motor vehicle crash data to hospital inpatient and emergency room data and death certificate data to study medical and cost outcomes of crashes; and provides data support to private organizations such as March of Dimes and MCH researchers at universities nationwide. BHI assisted in developing a web-based birth registration system utilizing the 2003 national birth certificate. This version collects additional information such as multiple races and ethnicities, clearer recording of birth defects, maternal smoking behavior, and mother's weight at the end of her pregnancy. The Vital Statistics system follows National Center for Health Statistics (NCHS) guidelines regarding collection and analysis of race and ethnicity data. Missouri will be implementing the State and Territorial Exchange of Vital Events (STEVE) System. STEVE is an innovative messaging application developed by NAPHSIS for the electronic exchange of vital event data between jurisdictions. STEVE replaces the current, less secure practice of exchanging paper copies, line lists and printed computer abstracts which most states use today for record exchange.

BHI produces and maintains the Missouri Information for Community Assessment System, an interactive system that allows the user to create and download tables, based on selected variables such as race, ethnicity, age, education, and location. The MICA system has many modules addressing maternal and child health, including births, fertility rate, pregnancies, WIC Prenatal, WIC Postpartum, WIC linked Prenatal-Postpartum, WIC Infant, and WIC Child. The Birth MICA module offers tables and maps for all counties, zip codes, and the three largest cities in Missouri. This module will undergo extensive changes this year to address the added information from the new birth certificate, and to incorporate new indicators such as BMI and BRFSS regions.

BHI also produces the Community Data Profiles which are resource pages that provide information on a variety of indicators that include MCH indicators. The Profiles include a definition of the indicator, risk factors, and descriptions of diseases and conditions. Our community profile system offers many profiles that contain maternal and child health indicators, including Child Health, Deliveries, Infant Health, Prenatal, Women's Health, and Minority Health. Most profiles are available with break out data by region, county, selected cities, and by race.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No
Pediatric Nutrition Surveillance System (PedNSS)	3	Yes
WIC Program data	3	Yes
Pregnancy Risk Assessment Monitoring System (PRAMS)	3	Yes

Notes - 2011

Narrative:
By combining forces with the Missouri Foundation for Health (MFH) and state advocacy groups, approximately 230 schools or youth groups around the state are now working on changing their communities' norms around tobacco use. Youth advocacy\prevention groups include Smokebusters and Youth Empowerment in Action Tobacco Education, Advocacy, and Media (YEA TEAM). Smokebusters is high school based and YEA TEAM is middle school based. Smokebusters started in northeast Missouri in 1999 and became active in 2005 on a limited basis in the northwest, southeast, and southwest. The state funding in 2008-2011 has allowed the program to spread to Kansas City and western Missouri and to more counties in the southwest. The YEA TEAM program started in the St. Louis area and the southeast in 2006. State funding from 2007-2011 has allowed the program to spread to more schools in the St. Louis area.

Based on the 2009 Youth Tobacco Survey the percentage of students in grades 9-12 who smoked on one or more of the previous 30 days decreased from 30.3 in 2003 to 19.4 in 2009.

In 2007-2009, youth advocacy and prevention programs organized at least 130 school or community groups in at least 67 counties. Over 3,800 youth were trained in advocacy and tobacco education and their efforts directly educated approximately 60,000 children and 37,000 adults.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The Missouri Title V Block Grant Performance Measurement System follows the MCHB system approach that begins with the needs assessment and identification of priorities and culminates in improved outcomes for the Title V population. After the priorities needs are established by the five-year statewide needs assessment, resources are assigned and program activities implemented to specifically address these priorities. State Performance Measures are then developed to supplement the National Performance Measures, Health Systems Capacity Indicators, Health Status Indicators, and National Outcome Measures. Progress is monitored by tracking each of these performance measures. Both budgeted dollars and expenditures are categorized and tracked across the four service levels in the MCH Pyramid: direct health care services, enabling services, population-based activities, and infrastructure-building activities. Because of the flexibility available with these funds the role the Title V agency plays in each performance measure may be different. The Life Course perspective was used as a framework for developing the state's performance measures. Missouri's view of the Life Course perspective is that it could not be encompassed in a specific priority or performance measure, but was the overarching theme use for the development of the state performance measures.

See Section II, Needs Assessment, for further details.

See Table 4b in D. State Performance Measures of Section IV Priorities, Performance and Program Activities and Form 16, State Performance Measure Detail Sheets, for descriptions of the state selected measures that includes their category on the pyramid, the Missouri goal, the measure used, how the measure is defined, the measure's relationship to Healthy People 2010 (if applicable), data sources and data issues and the significance of the indicator or why this particular indicator was chosen.
An attachment is included in this section.

B. State Priorities

As a part of the 2010 Five Year Needs Assessment process, Missouri identified ten MCH State Priority Needs. The National and State Performance Measures as they relate to Missouri's MCH State Priority Needs are shown below. The capacity of the state's Title V program related to the performance measures are discussed in the respective performance measure narrative.

1. IMPROVE HEALTH CARE ACCESS FOR MISSOURI MCH POPULATIONS

The performance measures related to this priority are:

SPM 10: Percent of children ages 0-19 years old who received health care at a FQHC.

NPM 2: The percent of children with special health care needs age 0 to 18 whose families partner in decision-making at all levels and are satisfied with the services they receive. (CSHCN survey)

NPM 3: The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN survey)

NPM 4: The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN survey)

NPM 5: The percent of children with special health care needs age 0 to 18 whose families report the community-based service system are organized so they can use them easily. (CSHCN Survey)

NPM 6: The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence. (CSHCN Survey)

NPM 13: Percent of children without health insurance.

NPM 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

NPM 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

2. PREVENT AND REDUCE SMOKING AMONG MISSOURI WOMEN AND ADOLESCENTS

The performance measures related to this priority are:

SPM 1: Percent of women aged 18-44 years who are current cigarette smokers.

SPM 2: Percent of cigarette smoking among high school students.

NPM 15: Percentage of women who smoke in the last three months of pregnancy.

3. REDUCE OBESITY AMONG MISSOURI WOMEN, CHILDREN AND ADOLESCENTS

The performance measures related to this priority are:

SPM 3: Percent of mothers who are prepregnancy overweight by 20% or more.

SPM 4: Percent of high school students who met currently recommended levels of physical activity.

NPM 14: Percentage of children, ages 2 to 5 years, receiving WIC services that have a Body Mass Index (BMI) at or above the 85th percentile.

4. IMPROVE THE MENTAL HEALTH STATUS OF MCH POPULATIONS IN MISSOURI

The performance measure related to this priority is:

SPM 8: Percentage of women with a recent live birth who reported frequent postpartum depressive symptoms.

5. ENHANCE ACCESS TO ORAL HEALTH CARE SERVICES FOR MISSOURI MCH POPULATIONS

The performance measures related to this priority are:

SPM 6: Percentage of women aged 18-44 who visited a dentist or a dental clinic for any reason within the past year.

NPM 9: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

6. IMPROVE PRECONCEPTION HEALTH AMONG MISSOURI WOMEN OF CHILDBEARING AGE

The performance measure related to this priority is:

SPM 7: Percentage of women with a recent live birth who reported taking a multivitamin or a prenatal vitamin four or more times per week in the month prior to pregnancy.

7. REDUCE THE RATE OF TEEN PREGNANCIES AND BIRTHS IN MISSOURI

The performance measures related to this priority are:

SPM 5: Birth rate (per 1,000) among teenage girls aged 15-19 years.

NPM 8: The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

8. REDUCE DISPARITIES IN ADVERSE BIRTH AND PREGNANCY OUTCOMES

Two National Outcome Measures are used to measure the performance towards this priority. They are:

NOM 1: Infant mortality rate per 1,000 live births.

NOM 2: Ratio of the black infant mortality rate to the white infant mortality rate.

9. REDUCE INTENTIONAL AND UNINTENTIONAL INJURIES AMONG WOMEN, CHILDREN AND ADOLESCENTS IN MISSOURI

The performance measures related to this priority are:

NPM 10: The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

NPM 16: The rate (per 100,000) of suicide deaths among youths 15-19.

10. SUPPORT ADEQUATE EARLY CHILDHOOD DEVELOPMENT AND EDUCATION SERVICES IN MISSOURI

The performance measures related to this priority are:

SPM 9: Percent of infants with permanent hearing loss and enrolled in appropriate early intervention services that are enrolled in those services by 6 months of age.

NPM 1: The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for conditions(s) mandated by their state-sponsored newborn screening programs.

NPM 7: Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.

NPM 11: The percent of mothers who breastfeed their infants at 6 months of age.

NPM 12: Percentage of newborns who have been screened for hearing before hospital discharge.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	92.4	99.2	96.2	98.6	100.0
Numerator	85	127	101	139	165
Denominator	92	128	105	141	165
Data Source				DHSS Bureau of Genetics and Healthy Childhood.	DHSS Bureau of Genetics and Healthy Childhood.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

Notes - 2009
Source: MO DHSS Bureau of Genetics and Healthy Childhood. Final calendar year.

Notes - 2008
Source: MO DHSS Bureau of Genetics and Healthy Childhood. Fatty Acid disorder infant who had a positive newborn screen for MCAD died from complications to MCAD soon after confirmation.

Notes - 2007
Decreasing percentages since 2005 are partially attributed to the increased number of conditions screened and the complexity of the follow up testing that leads to diagnosis which may require several months for completion.

a. Last Year's Accomplishments
Biotinidase deficiency was added to the newborn screening panel in December 2008. Missouri now screens for all conditions recommended by the American College of Medical Genetics and the March of Dimes. When considering secondary disorders detected through newborn screening (NBS), the State Public Health Laboratory currently performs screening for 67 genetic and metabolic disorders on all infants born in Missouri.

A one-day Missouri Genetic Conference, "Newborn Screening: What Providers and Parents Need to Know," was held in April 2009 in Jefferson City, MO. The conference goal was to provide professional and public education on the expansion of Missouri's newborn screening program. Attendees included health care professionals and families who had a child with a metabolic/genetic disorder or a hearing disorder. Conference topics included an overview of expanded newborn screening in Missouri, newborn hearing screening, a closer look at sickle cell disease, cultural competency, transitioning children with special health care needs to adult care, setting up parent support groups, and others.

Conference funding was made available through the Heartland Regional Genetics and Newborn Screening Collaborative (HRGNSC). Collaboration occurred between the Bureau of Genetics and Healthy Childhood (GHC) and the Bureau of Special Health Care Needs (SHCN). The SHCN identified parents of newborns and children with a condition detected through Missouri's newborn screening program as well as other families having a genetic condition. Approximately one hundred people attended.

Legislation was passed that expanded the newborn screening panel to include testing for five lysosomal storage disorders (Krabbe disease, Gaucher's disease, Niemann-Pick disease, Pompe disease, and Fabry's disease). These disorders will be added to the NBS panel by July 2012, funds permitting.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Developed reporting form for genetic tertiary center staff to report to the state on confirmatory test result for Biotinidase deficiency.		X		
2. Contracted with four genetic tertiary centers and cystic fibrosis centers to track and follow-up on babies with abnormal screen results.			X	
3. Revised newborn screening pamphlet to include information on biotinidase deficiency.			X	
4. Consulted with the Newborn Screening Standing Committee on the implementation of adding biotinidase deficiency to the newborn screening panel.			X	
5. Sponsored newborn screening conference for health care providers and parents.			X	
6. Participated in Heartland Regional Genetics and Newborn Screening Collaborative workshop on newborn screening and emergency preparedness.			X	
7. The NBS program works with HRGNSC, the four genetic tertiary centers, the four accredited CF Foundation centers, and SHCN to improve the detection, follow-up and treatment.			X	
8. The NBS program works with the Genetic Advisory Committee, the Newborn Screening Standing Committee, the Newborn Screening for CF Task Force as well as the CF Standing Committee, and the Sickle Cell Standing Committee.			X	
9. Contracts with the pediatric hemoglobinopathy centers for follow-up and treatment of children.			X	
10.				

b. Current Activities
Activities listed in Table 4a will be continued.

To improve the detection of Cystic Fibrosis (CF), the NBS program has lowered the IRT level from 100 to 85 at which an abnormal newborn screened result is reported and requires a sweat test. The program is researching the possibility of using testing methodology IRT/DNA from the current testing methodology IRT/IRT.

The Public Health Profile is expected to go public in the summer 2010. This is the brief electronic record of children which contains information concerning immunizations, newborn bloodspot screening, newborn hearing screening, special health care needs, child lead, and allergies. It will

provide a quick review of certain aspects of a child's health that will be available to public and private health care providers. The profile alerts providers if a newborn screening has not been done and if immunizations are not up-to-date.

Plans are being finalized to have staff at the four genetic tertiary centers use MOHSAIC as a short term tracking system on those infants who have an abnormal NBS result requiring follow-up. These four centers will begin entering data into MOHSAIC in the summer of 2010.

c. Plan for the Coming Year
Activities listed in Table 4a will be continued.

In 2009 legislation passed expanding the newborn screening (NBS) panel in calendar year 2012 to include testing for five lysosomal storage disorders - Krabbe disease, Pompe disease, Gaucher disease, Niemann-Pick disease, and Fabry disease. Missouri will be making plans in FFY2011 for a pilot program to commence in late 2011 or early 2012, funds permitting. Once screening commences, Missouri's NBS panel will be expanded to testing for 72 disorders from the current 67 disorders.

Missouri's Newborn Screening Laboratory is required to retain all NBS specimens for five years after testing has been completed. Retention of NBS specimens will begin in late 2011 and plans will be made as to how best to communicate this information to parents. Parents may opt out of having their child's NBS specimen released for anonymous scientific study upon notification to the department and request the specimen be: returned to them, destroyed, or stored by the department but not released for anonymous scientific study.

Modification to the Missouri Health Strategic Architectures and Information Cooperative (MOHSAIC) is nearing completion to allow contractors doing follow-up work with infants identified through newborn screening to enter information on confirmatory testing and follow-up. In addition, matching newborn blood spot screens with birth certificates will soon be possible and this will allow the Newborn Screening Program (NBSP) to detect those babies who have not had a newborn screen prior to hospital discharge. It is anticipated these features will be operational later this summer or fall and improvements will be made in FFY2011, if needed.

Partnering with the four genetic tertiary centers and the four accredited cystic fibrosis centers has been very successful and has resulted in increased communication among health care providers who provide treatment for these infants and children. Efforts will focus on continuing and enhancing these partnerships.

Please Note: On Form 6, more screens than provisional births is most likely a result of newborn screens being counted as an initial screen when they should have been counted as a repeat and thus are not linked. However, these situations can occur due to a combination of one or more of the following:
- name changes to the baby and/or mother or changes in the mother's address;
- babies who have been adopted and have an initial newborn screen under the new adoptive name when the screen should have been counted as a repeat;
- the baby being born in late December 2008 and the newborn screen was received in the lab in January 2009 and thus counted as an initial NBS for 2009; and
- babies born in a bordering state and are transferred for medical care to a Missouri hospital where they will often have a newborn screen in Missouri even though they were not born in Missouri.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**78631**					
Reporting Year:	**2009**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	78881	100.3	8	2	2	100.0
Congenital Hypothyroidism (Classical)	78881	100.3	46	38	38	100.0
Galactosemia (Classical)	78881	100.3	41	2	2	100.0
Sickle Cell Disease	78881	100.3	41	38	38	100.0
Biotinidase Deficiency	78881	100.3	26	18	18	100.0
Cystic Fibrosis	78881	100.3	81	24	24	100.0
Organic Acid Disorders	78881	100.3	34	10	10	100.0
Fatty acid Disorders	78881	100.3	39	17	17	100.0
Amino Acid disorders (excluding PKU)	78881	100.3	13	4	4	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	64.1	57.2	57.2	64.5	64.7
Annual Indicator	64.1	64.1	64.1	64.1	64.1
Numerator					
Denominator					
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and					

therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	64.9	65.1	65.3	65.5	65.7

Notes - 2009
Indicator data comes from the National Survey of CSHCN conducted by HRSA and CDC, 2005-2006. The next National Survey of CSHCN 2010 data release is Fall of 2011.

The 2005-2006 percentage 64.1% in Missouri was close to the 90th percentile state level of 64.2% and significantly higher than the national figure of 57.4%.

Trend analysis cannot be done until future data becomes available. An annual increase of 0.2% was chosen to create 2010-2014 objectives, based on past performance 2001 and 2005-2006, comparisons to other states, and discussions with the Bureau of Special Health Care Needs, MO DHSS.

Notes - 2008
Indicator data comes from the National Survey of CSHCN conducted by HRSA and CDC, 2005-2006. The next National Survey of CSHCN 2010 data release is fall of 2011.

The 2005-2006 percentage 64.1% in Missouri was close to the 90th percentile state level of 64.2% and significantly higher than the national figure of 57.4%.

Trend analysis cannot be done until future data becomes available. An annual increase of 0.2% was chosen to create 2009-2013 objectives, based on past performance 2001 and 2005-2006, comparisons to other states, and discussions with the Bureau of Special Health Care Needs, MO DHSS.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey, and data were comparable across the two time periods

Only two points of data are available, which prevent capacity of performing trend analysis. The 2005-2006 percentage in Missouri (64.1%) was close to the 90th percentile state level of 64.2%. An annual increase of 0.2% was chosen starting from 2006 to create 2008-2012 objectives, based on past performance 2001 and 2005-2006, comparisons to other states, and discussions with the Bureau of Special Health Care Needs, MO DHSS.

a. Last Year's Accomplishments
Special Health Care Needs (SHCN) provided service coordination for program participants/families. Service Coordinators completed Service Coordination Assessments (SCA), Service Plans and Transition Plans through collaboration with participants/families. The SCA included components consistent with federal data collection regarding participants/families reporting satisfaction with services and partnering in decision making. An electronic database was utilized for statewide collection of data. In FY2009, a total of 3,872 participants/families were served through the Children with Special Health Care Needs Program (CYSHCNP) and the Healthy Children and Youth Program (HCY).

SHCN maintained a contract for the Family Partnership Initiative and monitored the contract to assure quality. The Family Partnership Initiative focused on building a support network for family members. Family members provided input on specific special needs issues. Family Partners conducted outreach activities to increase participation. The Family Partnership Parent and Caregiver Retreat was held November 7-8, 2008 at the Best Western Columbia Inn. The Retreat

was attended by 104 parents and caregivers in addition to numerous professionals. A variety of information and resources regarding CYSHCN was shared with the attendees. Several breakout sessions were conducted and topics included: Alternatives to Guardianship; Transition Resources; Breaking the Myths about People with Disabilities; Personal Safety, and the Claim and Appeal Process. In addition, a Missouri State Representative discussed disability legislation and how families can work with their legislators to improve services for individuals with disabilities. The Retreat also provided an opportunity to conduct a family questionnaire. Information from the questionnaire was used to develop resources to assist family members in coping with addressing the unique needs of their children, to assist families in advocating for their children, and to promote families' involvement in leadership and volunteer roles.

Families and professionals partnered as decision makers in the implementation of grant activities for the Family to Family Health Information Center grant, the service integration grant, and the Improved Services for Children with Autism Spectrum Disorder and other Developmental Disabilities (Autism Grant). SHCN collaborated with the grantees and parents of CYSHCN in implementing grant activities. FY2009, family/professional partnerships developed to plan and guide improvements in the overall statewide integrated system of care for CYSHCN. Parents participated in the leadership teams to ensure that needs were fully integrated into system enhancements. In addition, a survey was developed through the service integration grant to obtain information from SHCN participants and family members regarding the value of service coordination.

The School Health Services Contract has a performance measure related to case management of a child with a special health care need or a chronic condition. One requirement is the goals set must be in agreement with parent and student's goals. Last year, 9,478 Asthma Action Plans, 7,933 Emergency Action Plans, and 2,814 Individualized Health Care Plans were developed.

Missouri Child Care Resource and Referral Network (MOCCRRN) assisted 3,145 families with CYSHCN in finding and maintaining child care that meets each family's needs and collected data regarding family's satisfaction with services. Inclusion Specialists worked with providers to create 279 new slots for CYSHCN. MOCCRRN trained child care providers and parents to accomplish goals of health needs and inclusion services.

In FFY 2009, the Child Care Health Consultation (CCHC) program provided 123 hours of on-site consultation, 114 phone consultations and 1,156 hours of group education to child care providers regarding the care of CYSHCN. Twenty-six health care actions plans for young children in child care were completed.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. SHCN contracts for assistive technology.	X	X		X
2. Various activities to assure culturally competent services for SHCN participants/families, including utilizing professional interpreters, translating materials, and participating in events to increase knowledge of cultural diversity.		X		X
3. SHCN Family Partnership Initiative (support network for family members) and participation in family focused coalitions.		X		X
4. Recruit SHCN providers and distributed the Provider Fact Sheet.		X		X
5. Professional development activities for SHCN staff and staff of contracted agencies.		X		X
6. SHCN service coordination for CYSHCN including assessments, service plans, transition plans, and emergency		X		X

preparedness.				
7. SHCN collaboration with grant activities including Family to Family Health Information Center, Service Integration, and Improved Services for Children with Autism Spectrum Disorder.		X		X
8. SHCN facilitation of the Missouri Head Injury Advisory Council and the Traumatic Brain Injury Grant.		X	X	X
9. Child care health consultation and education to child care providers related to the care of CYSHCN.		X	X	X
10. Individualized Health Care Plans, Emergency Action Plans, and Asthma Action Plans are developed by school nurse in collaboration with student and family.	X			

b. Current Activities
Activities listed in Table 4a will be continued.

Plans for sustainability of the Family to Family Health Information Center grant are underway as grant funding will end in 2010. Current SHCN activities include conducting the participant and family survey to gain input on the value of service coordination, as part of the service integration grant. The Family Partnership Parent and Caregiver Retreat was held in December 2009 in Osage Beach, Missouri. A current project of the Traumatic Brain Injury Grant is to facilitate a relationship between Brain Injury Association of MO and UMKC-IHD to allow access for peer mentoring services.

MOCCRRN assists families with CYSHCN in finding and maintaining child care and collects data regarding families' satisfaction. Inclusion Specialists provide technical assistance to child care providers.

c. Plan for the Coming Year
Activities listed in Table 4a will be continued.

In addition to these activities SHCN will develop with the Family Partnership a Facebook page to allow for the sharing of information and resources to families throughout the state as well as allow families to connect with each other and provide a means for Family Partners to support families on a larger scale.

The next Family Partnership Parent and Caregiver Retreat is scheduled for October 22-23, 2010 at the Inn at Grand Glaize, Osage Beach, Missouri. Topics planned to date include: The Power of Stories: Learning to Tell Your Story, presented by the University of Missouri-Kansas City, Institute for Human Development; Disability Legislation, presented by a Missouri Representative; Emergency Medical Services for CYSHCN and Their Families, presented by the University of Missouri-Kansas City, Institute for Human Development; Social Networking, presented by the University of Missouri-Kansas City, Institute for Human Development.

The family survey to gain input on the validity of service coordination will be evaluated to determine procedure improvements to better meet SHCN population needs.

The Integrated Services Grant will develop additional resources to best address the needs of individuals, families and professionals. In cooperation with partners and key stakeholders, staff will develop diagnosis specific packets on the following topics: Cystic Fibrosis, Asthma and ADHD.

The School Health Services program has a performance measure to increase the percent and number of children with chronic conditions and\or special health care needs participating in the development of an individualized health care plan to address mutually desired goal(s). Plans are

developed by the school nurse in collaboration with parent(s), the student, and the health care provider. For the next year, school nurse regional workshops will focus on culturally sensitive communication and health literacy. This program targets school districts in rural areas of Missouri with high poverty and includes nearly 300,000 children.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	59.6	60.6	61.6	52.2	52.4
Annual Indicator	51.8	51.8	51.8	51.8	51.8
Numerator					
Denominator					
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	52.6	52.8	53	53.2	53.4

Notes - 2009
Indicator data comes from the National Survey of CSHCN conducted by HRSA and CDC, 2005-2006. The next National Survey of CSHCN 2010 data release is fall of 2011.

The 2005-2006 percentage 51.8% in Missouri was close to the 75th percentile state level and significantly higher than the national figure of 47.1%

Trend analysis cannot be done until future data becomes available. An annual increase of 0.2% was chosen to create 2010-2014 objectives, based on data 2005-2006, comparisons to other states, and discussions with the Bureau of Special Health Care Needs, MO DHSS.

Notes - 2008
Indicator data comes from the National Survey of CSHCN conducted by HRSA and CDC, 2005-2006. The next National Survey of CSHCN 2010 data release is fall of 2011.

The 2005-2006 percentage 51.8% in Missouri was close to the 75th percentile state level and significantly higher than the national figure of 47.1%

Trend analysis cannot be done until future data becomes available. An annual increase of 0.2% was chosen to create 2009-2013 objectives, based on data 2005-2006, comparisons to other states, and discussions with the Bureau of Special Health Care Needs, MO DHSS.

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Trend analysis cannot be conducted until we have future data available. The 2005-2006 percentage in Missouri (51.8%) was close to the 75th percentile state level of 51.6%. An annual increase of 0.2% was chosen starting from 2006 to create 2008-2012 objectives, based on comparisons to other states, and discussions with the Bureau of Special Health Care Needs, MO DHSS.

a. Last Year's Accomplishments

Special Health Care Needs (SHCN) ensured coordinated ongoing comprehensive care for program participants through service coordination. In FY2009, a total of 3,872 participants/families were served through the Children with Special Health Care Needs Program (CYSHCNP) and the Healthy Children and Youth Program (HCY). Service Coordination Assessments (SCA) were completed with participants. The SCA is a comprehensive view of participant needs and contains criteria to identify whether the participant has a medical home, consistent with the American Academy of Pediatrics (AAP) definition of medical home. If it was determined the participant did not have a medical home, educational materials were provided to the family to ensure coordinated, ongoing, comprehensive care for SHCN participants.

In FY2009, medical home resources were disseminated and training materials were developed for both families and professionals through the Family to Family Health Information Center grant and the grant for service integration. SHCN partnered with Missouri Family Voices and University of Missouri Kansas City -- Institute for Human Development (UMKC-IHD) on the Family to Family Health Information Center grant. The goal of the project is to provide information, training, and personal support to families of CYSHCN. SHCN partnered with UMKC-IHD, who received the grant for service integration. The goal of this project is to improve and sustain access to quality, comprehensive, coordinated community based systems of services for CYSHCN and their families in Missouri.

Medical home is a component of a grant for Improved Services for Children with Autism Spectrum Disorder and other Developmental Disabilities (Autism Grant). SHCN partnered with the University of Missouri Columbia (UMC) Thompson Center, who received the grant. In FY2009, the Rapid Response initiative was expanded to develop a more integrated service delivery system that enhances the capacity of individual communities to respond to the needs of children and youth with Autism Spectrum Disorder (CY-ASD).

One Medicaid Managed Care provider, Blue-Advantage Plus of Kansas City along with TransforMED, a wholly owned subsidiary of the American Academy of Family Physicians, introduced a pilot program in which 13 primary care physician groups (family medicine, internal medicine and pediatrics) in the Kansas City area will adopt a new model of health care known as the patient-centered medical home. TransforMED's practice enhancement facilitators will work directly with doctors and their staff as they implement new technologies and processes to improve patient access and care outcomes, increase patient satisfaction, and reduce errors to lower health care costs.

The School Health Program tracks the number and percent of children and youth with an identified medical provider. For fiscal year 2009, 232,628 or 87% of the students had a regular source of medical care.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Service coordination for SHCN participants, including Service Coordination Assessments.		X		X
2. Statistical data collection regarding SHCN participants who report receiving care in a medical home.				X
3. SHCN promotion of medical home through education/training opportunities and distributing the Medical Home Fact Sheet.		X		X
4. SHCN collaboration with grant activities including Family to Family Health Information Center, Service Integration, and Improved Services for Children with Autism Spectrum Disorder.		X		X
5. CCHC program consultation and education to child care providers and young parents of children in child care regarding elements of comprehensive, coordinated care.		X	X	X
6. Track students in the School Health Services program with a regular source of medical care.		X	X	
7. Missouri Child Care Resource and Referral Network (MOCCRRN) provides technical assistance to families and providers about the importance of establishing and maintaining a medical home for CYSHCN.		X		X
8. Inclusion Specialists provide training and on-site technical assistance to child care providers on CYSHCN.		X		X
9. MOCCRRN provides referrals to First Steps and to the CYSHCNP.		X		
10. The School Health Services program informs families without a known medical provider of services in the community.		X	X	

b. Current Activities
Activities listed in Table 4a will be continued.

The Family Partnership Parent and Caregiver Retreat was held in December 2009. One of the sessions focused on medical home. SHCN continues to partner on the grant the Family to Family Health Information Center and the service integration grant. Current activities of both grants include providing training to family members of CYSHCN regarding the benefits of having a medical home and strategies for creating and supporting one. Plans for sustainability of the Family to Family Health Information Center grant are underway as grant funding will end in 2010. Activities of the Autism Grant focus on developing a more integrated service delivery system that enhances the capacity of individual communities to respond to the needs of CY-ASD through the Rapid Response initiative.

c. Plan for the Coming Year
Activities listed in Table 4a will be continued.

In addition to these activities SHCN will continue grant activities that include partnering with the Children's Mercy Hospital Medical Home Team (CMH) to develop a series of Medical Home Technology and Education Training Modules. The purpose of the training modules is to provide introductory information for extended family members and service providers who will be caring for CYSHCN. Topics for training modules include: Neonatal Intensive Care Unit Graduates, Care of the Tube-Fed Child, Care of the Child with Chronic Lung Needs, Rehabilitation Care, Dialysis, Asthma, and Ventilator Care. The training modules will be available online in addition to DVD format that families can take home.

The School Health Services Program has a performance measure to "increase the number and percent of students whose health records indicate an identified medical provider/clinic". School Nurses and Social workers work with students, parents, and providers to assure continuity of care. The program reaches nearly 300,000 school age children. The program will continue with

professional development activities related to health literacy, principles of social marketing and cultural competency.

MOCCRRN efforts will also include a focus on addressing the state priority need of "Improving the Mental Health Status of MCH Populations ".

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	67.8	68.4	69	64.8	64.8
Annual Indicator	64.8	64.8	64.8	64.8	64.8
Numerator					
Denominator					
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	64.9	65	65.1	65.2	65.3

Notes - 2009
Indicator data comes from the National Survey of CSHCN conducted by HRSA and CDC, 2005-2006. The next National Survey of CSHCN 2010 data release is Fall of 2011.

The percentage in Missouri in 2005-2006 (64.8%) was at the 65th percentile state level and slightly higher than the national level of 62%. Although there was a slight decrease in the measure from 2001 to 2005-06 in MO, the decrease was not statistically significant.

Trend analysis cannot be done until future data becomes available. With consideration of the economic environment and potential policy changes, it is difficult to make predictions on this measure. 2010-2014 objectives were based on data 2005-2006 and 2001, comparisons to other states, and discussions with the Bureau of Special Health Care Needs, MO DHSS.

Notes - 2008
Indicator data comes from the National Survey of CSHCN conducted by HRSA and CDC, 2005-2006. The next National Survey of CSHCN 2010 data release is Fall of 2011.

The percentage in Missouri in 2005-2006 (64.8%) was at the 65th percentile state level and slightly higher than the national level of 62%. Although there was a slight decrease in the measure from 2001 to 2005-06 in MO, the decrease was not statistically significant.

Trend analysis cannot be done until future data becomes available. With consideration of the

economic environment and potential policy changes, it is difficult to make predictions on this measure. 2009-2013 objectives were based on data 2005-2006 and 2001, comparisons to other states, and discussions with the Bureau of Special Health Care Needs, MO DHSS.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey, and the data were comparable across the two time periods.

Only two points of data are available, which prevent capacity of performing trend analysis. The 2005-06 percentage in Missouri (64.8%) was at the 65th percentile state level. In light of potential changes in policy and other environmental factors, it is difficult to make predictions on this measure. 2008-2012 objectives were chosen, based on comparisons to other states, and discussions with the Bureau of Special Health Care Needs, MO DHSS.

a. Last Year's Accomplishments
Special Health Care Needs (SHCN) administered Children and Youth with Special Health Care Needs Program (CYSHCNP) which provides early identification and health services and includes service coordination, diagnostic and treatment services involving medical care, hospitalization and aftercare to participants who require sub-specialty, specialty, preventive and primary care. Medicaid referral, or verification of active enrollment, was required of program participants. The CYSHCNP served 1,259 participants in FY2009.

SHCN also administered the Healthy Children and Youth (HCY) Program through a cooperative agreement with the Department of Social Services MO HealthNet Division (MHD) (Medicaid). The HCY Program implements a portion of Early Periodic Screening, Diagnosis Treatment (EPSDT) requirements, including assessing the need for in-home nursing services (such as personal care, nursing care, and skilled-nursing visits). SHCN staff prior authorized medically necessary in-home nursing services and provided service coordination for participants. 2,613 participants were served through the HCY program in FY2009.

In FY2009, SHCN Service Coordinators completed Service Coordination Assessments (SCA) with participants/families of the CYSHCNP and the HCY Program. The SCA included assessing insurance availability for medical, vision, and dental services. An electronic database was utilized for statewide collection of data. In addition, SHCN maintained standard protocols for Service Coordinators to monitor the status of Medicaid referrals and the ability to obtain participants' Medicaid status through data linkage with Department of Social Services (DSS). Service Coordinators also received training on how to assist potential participants in determining available resources for adequate insurance.

The SHCN Family Partnership Parent and Caregiver Retreat was held November 7-8, 2008 in Columbia, Missouri. The Retreat was attended by 104 parents and caregivers in addition to numerous professionals. A variety of information and resources related to CYSHCN was shared with the attendees, including a break out session presented by the Missouri Department of Insurance on the Claim and Appeal Process.

Child Care Health Consultation (CCHC) program is a resource for child care providers on information and referral to Medicaid, developmental screening and special needs service providers.

The School Health Services program (SHS) provided outreach to families with no or inadequate health insurance. Regional meetings were conducted with school nurses and school social workers to provide information regarding community-based systems such as FQHC's as well as tips to assist families enroll in Medicaid. Last year, 87% (or 232,628) students in the SHS program report a regular source of medical care.

Public School Districts (524) participate in an every other year survey of CYSHCN. The SHS had 95% participation in this survey. The survey is used in professional development planning and allocation of resources.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. SHCN administered the CYSHCNP and the Healthy Children and Youth Program.		X		X
2. SHCN Family Partnership Initiative (support network for family members).		X		X
3. SHCN utilized electronic database for statewide data collection consistent with federal data collection regarding adequacy of insurance and maintained data link with Department of Social Services to obtain participant Medicaid status.				X
4. SHCN provided service coordination for program participants, including completing Service Coordination Assessments. Standard protocols were maintained to monitor referrals. Service Coordinators received training.		X		X
5. SHCN distributed the Insurance Comparison Checklist and the Insurance Fact Sheet and collaborated with other entities to promote adequate insurance.		X		X
6. SHCN collaborated with managed care organizations, Systems of Care Boards, DSS, DMH, and DESE to obtain information about CYSHCN that transition within the systems of care.		X		X
7. SHCN collaborated with grant activities including Family to Family Health Information Center, Service Integration, and Improved Services for Children with Autism Spectrum Disorder.		X		X
8. CCHC Program providing resource information and assistance to child care providers and/or parents on accessing a system of comprehensive care for CYSHCN.		X	X	
9. Provided regional workshops for school nurses and school social workers regarding community-based systems such as FQHCs and tips for enrolling school-age children in Medicaid. A session was offered on culture competency and working with parents.			X	X
10. Missouri Child Care Resource and Referral Network (MOCCRRN) and School Health Services (SHS) provide families with Medicaid and FQHC information.		X	X	

b. Current Activities

Activities listed in Table 4a will be continued.

SHCN is enhancing the statewide electronic database to focus on Financial Management, to improve claims processing and payment for services. The Family Partnership Parent and Caregiver Retreat was held in December 2009 in Osage Beach, Missouri. The service integration grant and the grant to establish a Family to Family Health Information Center are developing resource packets related to insurance and health care financing which will be distributed to families. Plans for sustainability of the Family to Family Health Information Center grant are underway as grant funding will end in 2010. The Autism grant continues to develop written materials for families and professionals about possible ways to finance services for children and youth with Autism Spectrum Disorder.

CCHC program assists in the creation of individualized health care actions plans for CYSHCN.

c. Plan for the Coming Year
Activities listed in Table 4a will be continued.

It is anticipated that SHCN providers will begin using the electronic claims system.

The School Health Services Program has a performance measure to increase the percent and number of children with a regular source of medical care. The program plans to sponsor regional meetings with nurses and social workers employed by school districts on enrollment procedures for Medicaid, eligibility guidelines, and suggestions for frequently identified barriers. Additionally, the FQHC system will be highlighted. The program will send an email blast to 1,300 school nurses in Missouri regarding Medicaid with outreach information and posters for schools.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	80	81.6	83.2	90.5	90.7
Annual Indicator	90.1	90.1	90.1	90.1	90.1
Numerator					
Denominator					
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	90.9	91.1	91.3	91.5	91.7

Notes - 2009
Indicator data comes from the National Survey of CSHCN conducted by HRSA and CDC, 2005-2006. The next National Survey of CSHCN 2010 data release is Fall of 2011.

The percentage in Missouri in 2005-2006 (90.1%) was close to the 75th percentile state level and slightly higher than the national level of 89.1%.

Trend analysis cannot be done until future data becomes available. An annual increase of 0.2% was chosen to create 2010-2014 objectives, based on data 2005-2006, comparisons to other states, and discussions with the Bureau of Special Health Care Needs, MO DHSS.

Notes - 2008

Indicator data comes from the National Survey of CSHCN conducted by HRSA and CDC, 2005-2006. The next National Survey of CSHCN 2010 data release is Fall of 2011.

The percentage in Missouri in 2005-2006 (90.1%) was close to the 75th percentile state level, and slightly higher than the national level of 89.1%.

Trend analysis cannot be done until future data becomes available. An annual increase of 0.2% was chosen to create 2009-2013 objectives, based on data 2005-2006, comparisons to other states, and discussions with the Bureau of Special Health Care Needs, MO DHSS.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Trend analysis cannot be conducted until we have future data available. The 2005-06 percentage in Missouri (90.1%) was close to the 75th percentile state level of 90.8%. An annual increase of 0.2% was chosen starting from 2006 to create 2008-2012 objectives, based on comparisons to other states, and discussions with the Bureau of Special Health Care Needs, MO DHSS.

a. Last Year's Accomplishments
Special Health Care Needs (SHCN) administered the Healthy Children and Youth (HCY) Program and maintained Service Coordination contracts for the Children and Youth with Special Health Care Needs Program (CYSHCNP). In FY2009, a total of 3,872 participants/families were served through the HCY and CYSHCNP programs. Service Coordination Assessments (SCA), Service Plans and Transition Plans were completed with participants/families. Service Coordinators (SCs) discussed emergency preparedness with and contacted participants/families after significant weather events to assure participant safety and the success of disaster planning. SHCN participated in emergency preparedness activities to ensure populations of individuals with special health care needs were considered. SCs were regionally based to effectively connect participants/families with community resources. Statewide assessment data was consistent with federal data collection and included components to assess if services were organized and easy to use. In addition, SHCN recruited providers for the CYSHCNP.

Professional interpreters were utilized and publications were translated, enabling non-English speaking people to obtain program and service information. Demographics were monitored to continue addressing translation/interpreter issues. In FY2009, staff participated in events to increase knowledge of cultural diversity i.e., American Indian Council Symposium, West Central Multicultural Forum, Ozark Regional Alliance, Annual Ethnic Festival, Vietnamese Community Center, Community Works, Black Expo, East Regional Alliance of Minority Health, and Cross Cultural Interpreter training. Training regarding cultural sensitivity was provided at a statewide meeting in March 2009 for SHCN staff and SCs of contracted agencies.

The SHCN Assistive Technology contract improved access and independence of CYSHCN. The assistive technology/modifications provided were coordinated with families, medical homes, schools, and SCs. In FY2009, 38 projects were completed for 37 individuals/families including: ramps, bathroom modifications, vehicle modifications, stair lifts, and hearing/FM systems. Most of these modifications averaged over $2,000 each. Missouri Assistive Technology was able to leverage an additional $20,442 from other sources to supplement MCH funding. Communication with families, contractors, and SCs assured that the projects were completed satisfactorily and according to Americans with Disabilities Act (ADA) accessibility guidelines. Families from all areas of the state were served.

SHCN collaborated with external agencies to promote organized community-based service systems for CYSHCN and participated in statewide promotional activities, increasing knowledge,

understanding and availability of SHCN programs and services. In FY2009 SHCN exhibited at 20 conferences, contacting 2,258 individuals and distributing 2,447 pieces of literature. In addition, SHCN collaborated with the University of Missouri Leadership Education in Neurodevelopmental and Related Disabilities (LEND) Program to train health care professionals. SHCN staff also participated on the Planning Council for Developmental Disabilities. The CSHCN Director participated on the leadership team for the Family to Family Health Information Center grant, the service integration grant, and the Autism Spectrum Disorder grant. The CSHCN Director was also member of the Missouri Commission for Autism Spectrum Disorders and the Missouri Assistive Technology Council.

Through the Traumatic Brain Injury Grant, the "Missouri Greenbook: Living with Brain Injury" was created, which provides education about Traumatic Brain Injury and assist in acquisition of available resources.

The School Health Services (SHS) Program tracked children with referral completions for hearing and vision deficits. Last year, 79% of the students received community-based care related to failing a hearing screening and 86% for vision screening failure.

Missouri Child Care Resource and Referral Network (MOCCRRN) distributed child care resources and referral services information for CYSHCN at 186 local community events; provided access to training for child care providers through electronic training calendar; provided technical assistance for parents/providers regarding SHCN; made referrals to IDEA Part C (First Steps) Program, Thompson Center for Autism and Neurodevelopmental Disorders and other area resources.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Activities to assure culturally competent services for SHCN participants/families, including utilizing professional interpreters, translating materials, and participating in events to increase knowledge of cultural diversity.		X		X
2. SHCN contracts for assistive technology.	X	X		X
3. SHCN Family Partnership Initiative (support network for family members) Family Partners were regionally based to provide a local support system.		X		X
4. The SHCN HCY Program and CYSHCN Program provision of Service Coordination, including assessments, service plans, transition plans and emergency preparedness. CYSHCN Program provider recruitment.		X		X
5. SHCN participation in outreach activities and collaboration with external agencies.		X		X
6. SHCN collaboration with grant activities. SHCN facilitation of the Missouri Head Injury Advisory Council and the Traumatic Brain Injury Grant. SHCN participation in various commissions and councils.		X		X
7. SHCN promotion of professional development for Department staff and staff of contracted agencies.		X		X
8. Child Care Health Consultants provide consultation and education to child care providers and parents on delivery of comprehensive, consistent care to children with special health care needs.		X	X	
9. Performance measure in the School Health Services contract related to the number and percent of referral completions for	X	X	X	

vision and hearing screening failures.				
10. Concepts of Health Literacy are infused into the regional meetings with school nurses and school social workers.			X	

b. Current Activities
Activities listed in Table 4a will be continued.

SHCN participates on the DHSS Oral Health Workforce. Current grant activities include coordination with other state initiatives related to emergency preparedness and developing training materials for community emergency management systems and families of CYSHCN.

Principles of health literacy are infused into the SHS contract in an effort to assure increased referral completion. This year will begin the collection of data for the mandated vision screening for children in public schools in 1st and 3rd Grades.

MOCCRRN promotes inclusion services at local community events and physician offices and provides referrals to community services statewide in response to phone or electronic inquiries from families. Inclusion Specialists provide training to child care providers regarding the needs of families through the delivery of "Building Partnerships with Parents and Families", which is Module IV of Child Care plus, Missouri's standardized inclusion-related curriculum. CCHC provides consultation/education to child care providers on the care of CYSHCN.

c. Plan for the Coming Year
Activities listed in Table 4a will be continued.

SHCN is reviewing processes and streamlining operations to serve HCY participants in a more efficient manner. The family survey to gain input on the validity of service coordination will be evaluated to determine process improvements to better meet SHCN population needs. The next Family Partnership Parent and Caregiver Retreat is scheduled for October 22-23, 2010 at the Inn at Grand Glaize, Osage Beach, Missouri.

Principles of health literacy will be infused into the SHS contract in an effort to assure increased referral completion.

MOCCRRN will promote services at local community events; provide referrals to community services in phone calls with families; provide training to child care providers on needs of families through delivery of "Building Partnerships with Parents and Families". Efforts address state priority needs of adequate early childhood development and education, mental health status of MCH populations and reducing intentional and unintentional injuries among infants, children and adolescents.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	6	6.5	7	54.4	54.4
Annual Indicator	54.4	54.4	54.4	54.4	54.4
Numerator					
Denominator					
Data Source				National	National

				Survey of CSHCN	Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	54.5	54.6	54.7	54.8	54.9

Notes - 2009
Indicator data comes from the National Survey of CSHCN conducted by HRSA and CDC, 2005-2006. The next National Survey of CSHCN 2010 data release is Fall of 2011.

Missouri had the highest percentage of receiving services for transition to adulthood among all states in 2005-2006 (54.4%, MO vs. 41.2%, US).

Trend analysis cannot be done until future data becomes available. 2010-2014 objectives were chosen, based on data 2005-2006, comparisons to other states, and discussions with the Bureau of Special Health Care Needs, MO DHSS.

Notes - 2008
Indicator data comes from the National Survey of CSHCN conducted by HRSA and CDC, 2005-2006. The next National Survey of CSHCN 2010 data release is Fall of 2011.

Missouri had the highest percentage of receiving services for transition to adulthood among all states in 2005-2006 (54.4%, MO vs. 41.2%, US).

Trend analysis cannot be done until future data becomes available. 2009-2013 objectives were chosen, based on data 2005-2006, comparisons to other states, and discussions with the Bureau of Special Health Care Needs, MO DHSS.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Trend analysis cannot be conducted until we have future data available. Missouri had the highest percentage in this measure among all states in 2005-2006. 2008-2012 objectives were chosen, based on comparisons to other states, and discussions with the Bureau of Special Health Care Needs, MO DHSS.

a. Last Year's Accomplishments
Special Health Care Needs (SHCN) provided service coordination to participants of the Healthy Children and Youth (HCY) Program and the Children and Youth with Special Health Care Needs Program (CYSHCNP). In FY2009, a total of 3,872 participants/families were served through these programs. Service Coordinators (SCs) assisted participants and collaborated with key agencies to plan for transitions, utilizing several planning tools. Service Coordination Assessments (SCA) were completed with participants. The SCA includes components to assess if CYSHCN receive

necessary services and supports for transitions. SHCN staff provided training to SCs and identified participants who have upcoming life stage transitions. In addition, SHCN reviewed transition materials to determine if additional resources were necessary to improve transition planning.

SHCN conducted a statewide meeting in March 2009 for SHCN staff and Service Coordinators of contracted agencies. University of Missouri Kansas City Institute for Human Development (UMKC-IHD) presented on transition to adult care, in relation to connecting, supporting and partnering with families.

The University of Missouri Kansas City Institute for Human Development (UMKC-IHD) grant to establish a Family to Family Health Information Center included mentoring activities, supporting families to better navigate services and systems to make successful transitions. Through the UMKC-IHD service integration grant, a statewide youth leadership council was created to guide the design, implementation, and evaluation of project transition activities. The grant for Improved Services for Children with Autism Spectrum Disorder and other Developmental Disabilities through the Thompson Center at the University of Missouri Columbia focused efforts on developing ways the grant could allow for partnering with existing state youth leadership programs to support the inclusion of youth with Autism Spectrum Disorder in leadership development opportunities. The Rapid Response Committee developed a subgroup to address transition for youth with Autism Spectrum Disorder. The subcommittee members served in an advisory capacity and met to: begin development of a Transition Overview Training Module, identify possible activities for the Thompson Center and University Extension around youth, and plan content for a Youth Transition Page for the Thompson Center website. SHCN collaborated in activities for each of the grants, including the Rapid Response subgroup.

The SHCN Family Partnership Parent and Caregiver Retreat was held November 7-8, 2008 in Columbia, Missouri. The Retreat was attended by 104 parents and caregivers in addition to numerous professionals. A variety of information and resources related to CYSHCN was shared with the attendees, including a break out session specifically focused on transition resources.

ADOLESCENT SHORTS newsletters focused on transitioning CYSHCN to adult health care services and showcasing related DHSS services.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The SHCN Healthy Children and Youth Program and Children with Special Health Care Needs Program provision of Service Coordination, including assessments, service plans, and transition plans.		X		X
2. SHCN collaboration with adult programs and services and Children's Hospitals. (These hospitals have a strong focus on transition issues for youth with special health care needs.)		X		X
3. SHCN collaboration with grant activities including Family to Family Health Information Center, Service Integration, and Improved Services for Children with Autism Spectrum Disorder.		X		X
4. SHCN Family Partnership Initiative (support network for family members).		X		X
5. SHCN statistical data collection, consistent with federal data collection, regarding participants who report receiving services necessary to make transitions to all aspects of adult life.				X
6. SHCN training for Department staff and staff of contracted agencies.		X		X

7. ADOLESCENT SHORTS newsletter addressed health care transition recommendations regarding children with special health care needs.			X	
8.				
9.				
10.				

b. Current Activities
Activities listed in Table 4a will be continued.

The name of the "Children with Special Health Care Needs Program" has been changed to the "Children and Youth with Special Health Care Needs Program" to better reflect the population served through the program. The Family Partnership Parent and Caregiver Retreat, held in December 2009, included a presentation by UMKC-IHD on medical transition. UMKC-IHD also provided training regarding youth transitions at the CYSHCNP statewide meeting in March 2010. Ranken Jordan Pediatric Specialty Hospital and Shriner's Hospital presented at a statewide meeting for the HCY Program in March 2010. Transition and the Individualized Education Program (IEP) Process was also a topic of the HCY Program meeting. Current activities of the youth leadership council include initiating a research study to better understand how CYSHCN make successful transitions from pediatric health care to an adult system of care. Plans for sustainability of the Family to Family Health Information Center grant are underway as grant funding will end in 2010. SHCN continues to participate on the subcommittee for Rapid Response.

The Traumatic Brain Injury Grant Coordinator joined Council for Adolescent and School Health (CASH). ADOLESCENT SHORTS newsletter addressed transition after concussions/head injuries.

c. Plan for the Coming Year
Activities listed in Table 4a will be continued.

In preparation for re-application of the Physical Disabilities Waiver, SHCN will evaluate the needs of HCY participants to assist in assuring services are available as youth transition to adulthood.

Through the Integrated Services Grant Findings from the research study will be utilized to assist CYSHCN in improving transitions from pediatric health care to the adult system of care. The Youth Advisory Council plans to take the information collected from the research study to create a medical transition website. The website will include "testimonials" from the youth that highlight specific areas of medical transition.

Through CASH and Adolescent Medicine Consultation services contract, health care transition issues of all adolescents including CYSHCN will be addressed through training for health providers, newsletters, and potential collaboration with DHSS, Missouri Chapter of the American Academy of Pediatrics, and Georgetown University to implement Bright Futures toolkit with health providers who care for teens.

CYSHCN are one of the vulnerable populations being considered in Missouri's Sexual Violence Primary Prevention Plan; several DHSS programs will collaborate on related strategies.

The Heartland Regional Genetics and Newborn Screening collaborative for which Missouri is one of the eight participating states has established a work group to determine the transition needs of children with Phenylketonuria.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	81.6	85.2	82.3	82.9	80.4
Annual Indicator	79.3	79.7	82.1	74.0	71.8
Numerator	61029	61934	64487	60201	58792
Denominator	76960	77709	78547	81353	81883
Data Source				National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	72.3	72.8	73.3	73.8	74.3

Notes - 2009
Data is for the 4:3:1:3:3 Series, US, National Immunization Survey, Q3/2008-Q2/2009. Population of infants <1 year of age in 2007 used as denominator estimate of 19-35 month olds in 2009. Population Source: DHSS Missouri Information for Community Assessment (MICA)-Population.

Both MO and the nation have seen a decrease in the rate of childhood vaccination coverage for two consecutive years 2008-2009. Prior to 2008, MO's rates were generally comparable with the national rates; MO's rates had tended to be lower than the national rates since 2008 though the difference was not statistically significant.

The MO DHSS Immunization Program has been adding more health care providers to the Vaccines for Children program. However, many private health care providers have declined carrying vaccines in their practice due to cost and they refer these patients to local public health agencies, community health centers, etc.

The Hib vaccine supply has been re-established and health care providers are able to re-call children to receive their full immunization. However, it is harder to accomplish the re-call for immunization than taking advantage of an already scheduled visit during which time the vaccine would have been provided.

An annual increase of 0.5% was set up for objectives 2010-2014, based on discussions with the MO DHSS Immunization Program.

Notes - 2008
Source: Data is the 4:3:1:3:3 Series (4 DTP, 3 Polio, 1 MMR, 3 Hib, 3 HepB)
CDC National Immunization Survey, Q3/2007-Q2/2008. July 2007-June 2008. Population of infants < 1 year of age in 2006 as denominator estimate of 19-35 months old in 2008.

The immunization rate among children in Missouri had been gradually rising from 72.1% in 1999

to 82.1% in 2007, and comparable with the national figure. The percentage in Missouri in 2008 was lower than that in 2007 and the national estimate in 2008, though the difference was not statistically significant.

MO encountered shortages and delays in Hib vaccine in 2008, which is expected to be resolved in 2009. Some private providers have either discontinued participation in the Vaccines for Children Program or stopped carrying vaccines altogether.

Considering the overall increasing trend in the past 10 years and possible data fluctuation, it is too early to tell the drop in 2008 is a start of decline. Objectives 2009-2013 were based on a combination of trend analyses on data 1999-2008 and discussions with the DHSS Immunization Program.

Notes - 2007
Data is for the 4:3:1:3:3 Series, US, National Immunization Survey, Q3/2006-Q2/2007. Population of infants <1 year of age in 2005 used as denominator estimate of 19-35 month olds in 2007. 2008-2012 objectives are based on trend analysis on data 1998-2007, and discussions with the immunization program, MO DHSS.

a. Last Year's Accomplishments
The Child Care Health Consultation (CCHC) program provided 71 hours of on-site consultation/technical assistance to child care facilities, 192 phone consultations, and 24 hours of group training to child care providers on keeping immunization records current and on completion of mandatory immunization reporting for child care providers.

MCH Coordinated Systems staff supported LPHAs efforts to assure appropriate immunizations for children through technical and consultative services. LPHAs promoted and provided H1N1 vaccine to children and families in this age group.

Baby Your Baby website (http://www.dhss.mo.gov/babyyourbaby) and Baby Your Baby Health Keepsake Books provided information for pregnant women, their families, and communities on healthy pregnancies and healthy babies. Topics include prenatal care, immunizations, and well child checkups. Baby Your Baby Books and other maternal child health educational resources were distributed to health care providers, health educators and Missouri families through the DHSS warehouse and at nine statewide exhibits. In 2009, Baby Your Baby distributed 30,483 books in English and 1,924 books in Spanish that provided information on immunization schedules. In addition 75,049 Baby Your Baby newsletters were distributed with information on children from birth to 2 years of age.

The Missouri Community-Based Home Visiting, Nurse Family Partnership (Building Blocks of Missouri) Home Visiting, and Alternatives to Abortion programs educate their clients on the importance of immunizations for newborns to age two. The two home visiting programs collect data on immunization status of infants through age two and assist their clients in scheduling visits should they fall behind. The Missouri Community Based Home Visiting program served 815 families and the Building Blocks Program served 446 families. In the Building Blocks program 90% were up to date with immunizations at age two. In the Missouri Community-Based Home Visiting Program 88% were up to date with immunizations.

Medicaid Managed Care plans have focused on improving immunization rates as a Performance Improvement Project. Immunization schedules were mailed to parents with "Come in for Care" postcards.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. LPHAs through MCH Coordinated Systems promoted and provided recommended immunizations to this age group, including H1N1 vaccine through routine clinics, WIC, and other community outreach.		X	X	X
2. Baby Your Baby Website and Baby Your Baby Health Keepsake Books provided information for pregnant women, their families, and communities on healthy pregnancies and healthy babies. The Website will remain active through January 2013.			X	
3. The Missouri Community-Based Home Visiting, Nurse Family Partnership (Building Blocks of Missouri) Home Visiting, and Alternatives to Abortion programs educate their clients on the importance of immunizations for newborns and infants.		X	X	
4. TEL-LINK, the toll-free information and referral line for maternal and child health services provided referrals for immunizations and distributed brochures to attendees at various health fairs.			X	
5. Child Care Health Consultants (CCHCs) provided consultation and training to child care providers regarding immunizations for children enrolled in child care.		X	X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Activities listed in Table 4a will be continued.

The CCHC educates child care providers on the importance of immunizations, monitors immunization compliance, and assists in development of immunization policy in child care settings. In the first half of the FFY 2010 contract year, compliance with mandatory immunization reporting has improved from 72% to 85%.

The Missouri Community-Based Home Visiting and Nurse Family Partnership (Building Blocks of Missouri) Home Visiting programs educate their clients on the importance of immunizations for newborns to age two. Clients are assisted with scheduling appointments if needed. In 2010, the home visitors promoted the importance of seasonal and H1N1 vaccinations to the target populations.

DHSS has joined with the National Healthy Mothers, Healthy Babies (HMHB) Coalition to promote text4baby, a free mobile information service that offers weekly text messages to pregnant women and new moms. Text4baby messages include the importance of immunizations and well baby checkups.

DHSS requires Alternatives to Abortion providers who provided education to their clients, to educate on immunizations as a condition of funding.

c. Plan for the Coming Year
Activities listed in Table 4a will be continued.

The Missouri Community-Based Home Visiting, Nurse Family Partnership (Building Blocks of Missouri) Home Visiting programs will continue to educate their clients on the importance of immunizations for newborns to age two and collect data on the infant's immunizations status through age two of the index child. Clients are assisted with scheduling appointments should they

fall behind. The home visitors will also promote the importance of seasonal influenza immunizations to the target populations including pregnant and parenting women to help protect their children from these illnesses and for infants old enough to receive the vaccines. DHSS requires Alternatives to Abortion providers who provide individual or group prenatal and parenting education to their clients to educate on immunizations as one of the mandatory education topics.

DHSS will explore opportunities to promote the text4baby free mobile messaging service.

MCH Coordinated Systems program will continue to support LPHA efforts to assure appropriate immunizations for children through technical and consultative services as needed and by allowing funding to be used to enhance this effort.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	19.6	18.4	17.2	21.4	21
Annual Indicator	20.8	22.6	21.4	21.6	19.2
Numerator	2555	2828	2685	2662	2368
Denominator	123065	124936	125231	123266	123266
Data Source				MO DHSS. Vital Statistics	MO DHSS. Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	19.2	18.9	18.4	17.9	17.4

Notes - 2009
Source: Missouri Information for Community Assessment (MICA)-Births, DHSS Vital Statistics, MICA-Population. Numerator is provisional 2009 birth number to women age 15-17 years as of April 2010. Final data will be available November 2010. Denominator is 2008 population number being used as proxy for 2009. Final population data will be available November 2010.

Numerator and denominator for 2008 are updated with 2008 final birth number and 2008 population estimate respectively.

The birth rate among girls 15-17 years of age in MO was 19.2 per 1,000 in 2009 (provisional), which decreased by 11.1% compared with the rate in 2008 (21.6 per 1,000).

The Adolescent Health Program, MO DHSS is in the process of applying for several federal funded teen pregnancy prevention grants. Other organizations across the state are also planning for applying grants that support evidence-based teen pregnancy prevention initiatives and strategies to reach teens. Considering these efforts, MO expects to see a gradual decrease in

teen birth rate in the next few years especially since the implementation of the potential programs in 2011.

Notes - 2008
Source: Missouri Information for Community Assessment (MICA)-Births, DHSS Vital Statistics, MICA-Population. Numerator is provisional 2008 birth number to women age 15-17 years as April 2009. Final data will be available October 2009. Denominator is 2007 population number being used as proxy for 2008. Final population data will be available November 2009.

The increase in teen birth rate observed in both Missouri and the U.S. in 2006 did not continue in Missouri. Missouri had seen decline for two consecutive years 2007 and 2008 since 2006, and the decrease was across white, African-American, and Hispanic groups. The 2008 provisional teen birth rate in MO was highest in Hispanics (49.4 per 1,000), followed by African-Americans (41.4 per 1,000) and whites (17.2 per 1,000). An annual decrease of 0.2 per 1,000 was chosen to create 2009-2013 targets, based on data in the past two years, and discussions with the DHSS Section of Healthy Families and Youth.

Notes - 2007
Source: Missouri Information for Community Assessment (MICA) Birth, MICA Population, and Bureau of Health Informatics, MO DHSS. 2007 provisional data as of April 28, 2008. 2007 final data of birth file will be available in October, 2008. 2007 denominator of population estimate for females 15-17 years of age is not available yet, and 2006 population estimate is used as a proxy for 2007. 2007 population estimate will be available in November, 2008.

An annual decrease of 0.2 per 1,000 was set to create future objectives 2008-2012, with considerations of trend analyses on past performance 1998-2007, as well as the fact the teem birth rate rose in 2006 for the first time in the past 15 years in both Missouri and the nation.

a. Last Year's Accomplishments
MCH Coordinated Systems staff provided resources and consultation to communities on best practices to address teen pregnancy, and collaborated with School Health Services (SHS) program and Adolescent Health Program (AHP) to link Local Public Health Agencies (LPHAs) with schools and other community partners around this issue. Staff participated on Council Adolescent and School Health (CASH) and encouraged LPHAs to be represented on local School Health Advisory Committees.

Four LPHAs implemented Teen Outreach Program (TOP) with school/community partners. TOP is an evidence-based teen pregnancy prevention/youth development program. Wyman provided training and 352 youth participated.

From 2008 to 2009, Local Public Health Agency (LPHA) contractors increased the number of TOP clubs from 9 to 17 and the number of youth served from 165 to 354.

Missouri's State-Local Team was one of five states selected by AMCHP and NACCHO to develop evidence-based approaches for teen pregnancy prevention, HIV/STD prevention. Contracted with Mississippi County Health Department to develop model and a similar model began replication in Miller County.

Missouri's Reconvene Team strengthened state public health and education agency collaboration to address teen pregnancy, STDs, and HIV. The Reconvene Team, CASH, and Coordinated School Health Coalition collaboratively submitted recommendations to Department of Elementary and Secondary Education (DESE) to include "medically accurate" language in new school improvement standards for health education. AHP received a $5,000 grant to sponsor workshops on best practices/effective strategies at state and regional conferences.

Missouri is one of six states selected by AMCHP for Preconception Health for Adolescents Action

Learning Collaborative (ALC) to develop innovative strategies that support CDC recommendations. Missouri will implement actions to address these objectives: 1) Reframe preconception health in an innovative way to attract and motivate young people: 2) Enhance existing school-offered curricula regarding preconception health issues with teens in family and consumer sciences and health education classes: and 3) Inform statewide initiatives that address preconception health. DHSS will work with various partners as available.

Contractors provided abstinence education for adolescents and parent communication strategies for 18,182 clients. Statewide Talk with Me media campaign encouraged parents to talk with their kids about sex, values, and healthy decisions. During June and July 2009, 686 television and 11,270 radio spots aired statewide. Information is available on the web at www.dhss.mo.gov/AdolescentHealth.

DHSS co-sponsored trainings on adolescent health with local/state health care, school, and parent organizations; includes Region VII HIV/AIDS/STDs & Human Sexuality Education conference.

CASH, HIV/STD and Teen Pregnancy Education Youth Committee promote best practices "Take control Take the test" campaign for STD/HIV awareness and screening.

The Missouri Community-Based Home Visiting and the Nurse Family Partnership (Building Blocks of Missouri) Home Visiting programs collected data on the number of women who are using a method of "family planning" following delivery and the number of repeat pregnancies while the home visitor is following the mother and the index child. Eight-four percent of the women enrolled in the Building Blocks program did not have a repeat pregnancy within 18 months from the birth of their 1st child.

Surveys were conducted to assess both teacher and student interests and learning needs; 85 teachers and 517 students completed surveys. The results will inform the development of new strategies and curricula resources to address preconception health. Over 200 Family and Consumer Science classrooms received health education "starter kits" of DHSS materials. Missouri received $2,500 grant to support youth involvement in this initiative.

Twenty-eight sets of infant simulator dolls, including those with Fetal Alcohol Syndrome and drug exposure were distributed to LPHA's, Family Counseling Centers, CSTAR programs, Maternal, Child and Family (MCF) Health Coalitions, HV programs and other partners who provide training for staff and clients.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MCH Coordinated Systems staff offered consultation and technical assistance to school nurses, LPHAs and community collaboratives on evidence-based practices to address teen pregnancy.		X	X	X
2. The Missouri Community-Based Home Visiting and the Nurse Family Partnership (Building Blocks of Missouri) Home Visiting programs educate their clients on the importance of birth spacing. This included available methods of contraception.		X	X	
3. Alternatives to Abortion providers who provide individual or group prenatal and parenting education to their clients post-partum to educate on the importance of birth spacing as one of the mandatory education topics.		X	X	
4. Adolescent medicine and health consultation contract supported services of board-certified Adolescent Medicine		X	X	

Consultant, training and technical assistance to adolescent health providers, ADOLESCENT SHORTS newsletter.				
5. DHSS and DESE joined public health and education agencies for Kansas, Iowa, and Nebraska in co-sponsoring regional HIV/AIDS/STDs and Human Sexuality Education conference.		X	X	
6. Teen Outreach Program (TOP) with LPHAs and community partners.		X		
7. Three Missouri Collaborative Teams are working with national, state, and community partners to address teen pregnancy, STD and HIV prevention, and preconception health for adolescents.		X		
8. Baby Your Baby Health Keepsake Books and Baby Your Baby Website provide preconception health care education for women of childbearing age, including teenagers aged 15 through 17.			X	
9.				
10.				

b. Current Activities
Activities listed in Table 4a will be continued.

Missouri's Preconception Health for Adolescents ALC Team including DHSS, DESE, youth representatives, Missouri Foundation for Health (MFH), Teen Pregnancy Prevention & Partnership (TPPP) is collaboratively working on strategies to: 1) reframe "preconception health" in meaningful way to engage youth and 2) enhancing health and family and consumer sciences curricula on preconception health-related topics.

TOP has expanded to five LPHAs. Wyman provides training and technical assistance. The Wyman Center developed an electronic reporting system that the contractors will begin using in 2010 to evaluate youth participant outcomes across programs and throughout the state and nation.

AHP co-sponsors conferences/workshops with community, state, and regional organizations, including the St. Louis Maternal, Child and Family Health Coalition conference on adolescent preconception health and the annual HIV/AIDS/STD & Human Sexuality Education conference.

DHSS presented data and collaborative efforts at TPPP kick-off meetings to begin developing a statewide teen pregnancy prevention organization.

DHSS Adolescent Health webpage is being updated and will include new adolescent sexual health resources.

MCH Coordinated Systems program staff will support and participate in newly forming regional/statewide teen pregnancy coalition.

c. Plan for the Coming Year
Activities listed in Table 4a will be continued.

Additional resources will be explored to replicate TOP in Missouri. Grant applications to expand evidence-based teen pregnancy/STD prevention programs will be pursued and implemented if funded.

Missouri's Preconception Health for Adolescents ALC Team will include activities to: 1) Reframe preconception health in an innovative way to attract and motivate young people: 2) Enhance existing school-offered curricula regarding preconception health issues with teens in family and consumer sciences and health education classes: and 3) Inform statewide initiatives that address preconception health. DHSS will work with various partners as available.

Results from 85 teacher and 517 student surveys compiled in 2010, identified preconception health interests and learning needs; results will be used to inform the development of educational resources.

DHSS will co-sponsor trainings on evidence-based teen pregnancy/STD prevention programs and best practices, current adolescent health care issues with local/state health care, school, parent organizations, including Region VII HIV/AIDS/STD and Human Sexuality Education conference.

DHSS Adolescent Health webpage will be updated with the latest information on teen sexual health and information for parents as recommend by the website user survey.

CASH, LPHAs, statewide Teen Pregnancy & Prevention Partnership, state Title X, state HIV/STD and Teen Pregnancy Education Youth Committee and local youth advisory committees will collaborate on various initiatives to promote services and best practices.

The Missouri Community-Based Home Visiting and the Nurse Family Partnership (Building Blocks of Missouri) Home Visiting programs will continue to collect data on the number of women who are using a method of "family planning" following delivery and the number of repeat pregnancies while the home visitors is following the mother and the index child. It is hoped that the number of clients served through Nurse Family Partnership (Building Blocks of Missouri) Home Visiting programs will be expanded in FY2011 due to increased funding.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	14	30	35	31.6	32.6
Annual Indicator	28.6	28.6	28.6	28.6	24.4
Numerator	18686	18795	19355	19252	16675
Denominator	65337	65718	67677	67314	68340
Data Source				Missouri Oral Health Survey	Missouri Oral Health Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	29.1	29.2	29.3	29.4	29.5

Notes - 2009
Source: Missouri Oral Health Survey 2009-2010. Denominator is 3rd grade Fall enrollment figure for 2008-2009 school year, from the Missouri Dept of Elementary & Secondary Education. Numerator is estimated based on the 2009-2010 percentage.

The Missouri Oral Health Survey 2009-2010 encountered low rate of school participation due to the H1N1 flu severely impacting school attendance. A convenience sample of 15 schools participating in the Missouri oral health program were added to the sampling frame. Therefore, the 2009-2010 data may not be generalizable to all third grade children in Missouri.

There has been a decrease in school based dental sealant programs in Missouri because of funding constraints. A slight increase of 0.1% per year based on 2005 data was chosen to create future objectives for 2010-2014, with consideration of both past performance and discussions with the DHSS Oral Health Program.

Notes - 2008
Source: Missouri Oral Health Survey conducted every five years. The most recent data from the 2005 Missouri Oral Health Survey is used as proxy for 2008. Denominator is 3rd grade Fall enrollment figure for 2007-2008 school year, from the Missouri Dept of Elementary & Secondary Education. Numerator is estimated based on the 2005 percentage.

An annual increase of 1% starting from 2005 was chosen to create future objectives for 2009-2013, with consideration of both past performance and discussions with the DHSS Oral Health Program.

Notes - 2007
Missouri Oral Health Survey was conducted every five years. The most recent data from the 2005 Missouri Oral Health Survey is used as proxy for 2007. Denominator is 3rd grade Fall enrollment figure for 2006-2007 school year. Numerator is estimated based on the 2005 percent.

An annual increase of 1% starting from 2005 was chosen to create future objectives for 2008-2012, with consideration of both past performance and discussions with staff from the Oral Health Program, Missouri Department of Health and Senior Services.

a. Last Year's Accomplishments
Currently the Oral Health Program does not have a sealant program. However, over 35,000 children were provided fluoride varnish application during the 2008-2009 school year.

The Child Care Health Consultation (CCHC) program provided 90 hours of consultation or group training to child care providers and parents of young children in child care on the importance of oral health in young children including the benefits of dental sealants.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Fluoride varnish applied through the Oral Health's Preventative Services Program (PSP).	X	X		
2. CCHCs provided consultation/education to child care providers regarding the importance of dental health in young children including the benefits of dental sealants.		X	X	
3. TEL-LINK will refer those who request information to federally qualified health centers and other facilities that provide dental care.		X		
4.				
5.				
6.				
7.				
8.				
9.				

10.				

b. Current Activities
Activities listed in Table 4a will be continued.

The Missouri Oral Health Survey conducted every five years was initiated in January 2010 and the survey process has recently been completed. Data from the survey has been collected and is in the process of being analyzed. The survey indicated significant decreases from 2005 to 2010 among 3rd Grade African American youth identified with untreated decay (42.3% to 29%), needing dental treatment (46.8% to 27.8%), and needing urgent dental treatment (7.7% to 4.8%). However, these indicators continue to lag behind Caucasian youth. Untreated decay also showed a decline from 2005 to 2010 for both the 3rd Grade (27% to 25.2%) and 6th Grade (22.2% to 17.8%) participants.

Additionally, the Oral Health Program has written two grants this period that would allow for school based sealant programs. The program has received notification they did not receive one of the grants, but are expecting notification on the second grant award in September 2010.

c. Plan for the Coming Year
Activities listed in Table 4a will be continued.

The School Health Services Program will fund school health services contracts in small rural areas of Missouri. These contractors are required to be advised by a School Health Advisory Council (SHAC) comprised of community and school members. Many SHACs have accepted the challenge of working with the community to find dental services for children. One of the performance measures in the contract is to increase the percentage of children receiving topical fluoride.

The Oral Health Program (OHP) has responded to a Health Resources and Services Administration (HRSA) and Center for Disease Control and Prevention Grant (CDC) funding opportunities for the expansion of sealant programs for children. Additionally, the OHP will continue to collaborate with Local Public Health Departments (LPHA) and other entities offering sealant programs.

The Oral Health Program (OHP) is awaiting 2008 data: trends will be reviewed. The counties with the 10 highest rates of ER visits for diseases of the tooth and jaw pain will be prioritized to receive PSP services. Further the OHP will continue to work with the Office of Primary Care and Rural Health (OPCRH) in effort to increase access to dental and medical primary care through increased Federally Qualified Health Center (FQHC) access. Additionally the OPCRH has health professional loan and loan repayment programs that increase access to healthcare in underserved areas and for vulnerable populations. Increased access to appropriate preventive dental care decreases the need for emergency care.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	3.3	3.7	3.5	3.5	3.1
Annual Indicator	3.7	3.6	3.6	3.1	2.7
Numerator	43	42	42	36	32
Denominator	1162408	1161417	1169228	1170036	1170036

Data Source				MO DHSS. Vital Statistics	MO DHSS. Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	2.7	2.6	2.6	2.5	2.5

Notes - 2009
Source: Missouri Information for Community Assessment (MICA) - Death, Missouri Vital Statistics, MO DHSS. 2009 provisional death data as of April 2010. 2009 final death data will be available in November 2010. 2008 population estimate is used as a proxy for 2009. The 2009 population estimate for specific age groups will be available in November 2010.

Numerator and denominator for 2008 are updated with 2008 final death number and 2008 population estimate.

The death rate due to MVC among children under 15 in MO further decreased from 3.1 in 2008 to 2.7 per 100,000 in 2009 (provisional), though the decrease was not statistically significant. A gradual decrease of 0.1 per 100,000 for every two years was chosen to create objectives 2010-2014, based on a combination of trend analysis on data 1999-2009, and discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2008
Source: Missouri Information for Community Assessment (MICA) Death, Missouri Vital Statistics, Bureau of Health Informatics, MO DHSS. 2008 provisional death data as of April 2009. 2008 final death data will be available in November 2009. 2008 denominator of population estimate under 15 years of age is not available yet, and 2007 population estimate is used as a proxy for 2008. 2008 population estimate for specific age groups will be available in November 2009.

The death rate due to MVC among children under 15 in MO decreased from 3.6 in 2007 to 3.1 per 100,000 in 2008, though the decrease was not statistically significant. A gradual decrease of 0.1 per 100,000 for every two years was chosen to create objectives 2009-2013, based on a combination of trend analysis on data 1999-2008, and discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2007
Source: Missouri Information for Community Assessment (MICA) Death,
and Bureau of Health Informatics, MO DHSS. 2007provisional death data as of April 28, 2008. 2007 final death data will be available in November, 2008. 2007 denominator of population estimate under 15 years of age is not available yet, and 2006 population estimate is used as a proxy for 2007. 2007 population estimate for specific age groups will be available in November 2008.

Future objectives 2008-2012 were based on trend analysis on data 1999-2007, and discussions with the Section of Healthy Families and Youth, MO DHSS.

a. Last Year's Accomplishments

LPHAs, through MCH Coordinated Systems contracts, addressed injury prevention as a health priority issue with community, regional and state partners such as parents, child care providers, schools, local businesses, law enforcement, fire departments, SAFE KIDS Coalitions, Missouri Department of Transportation (MODOT), Missouri State Highway Patrol, Missouri Water Patrol, Child Fatality Review Teams, WIC, Parents as Teachers and others. Evidence-based interventions implemented were determined by community collaboratives and included car seat and booster seat fitting stations/distribution and campaigns to increase awareness of booster seat laws, promotion/distribution of life jackets for children 7 and younger at large recreational lake, ATV safety, bicycle safety and helmet use, and seat belt use. MODOT 2009 data showed 10% overall drop in highway fatalities compared to 2008.

The Bureau of Genetics and Healthy Childhood (GHC) developed a series of car seat safety cards to educate families on car seat safety. Series included safety during pregnancy and safety for premature infants, infants, toddlers, and adolescents. Safety cards started being distributed in FY2009 through the DHSS warehouse and at statewide conference exhibits. The numbers distributed will not be known until FY2010.

The Missouri Community-Based Home Visiting, Nurse Family Partnership (Building Blocks of Missouri) Home Visiting, and Alternatives to Abortion programs educate their clients on the laws related to car seat safety for their newborns and other children. Car seats are provided as indicated through the Alternatives to Abortion program and the home visitors are provided with car seats through donated funds or Safe Kids providers to distribute to their clients.

Eight Missouri Safe Kids coalitions provided child passenger safety prevention information through safety fairs. Car seat safety checks were provided in 50 counties, Kansas City, and St. Louis City. Assistance was provided for obtaining car seats and for proper car seat installation. The coalitions worked closely with trauma centers, local public health agencies, and law enforcement to reinforce child passenger safety.

LPHAs implemented strategies to reach families with children for car/booster seat, seat belt, bicycle and ATV safety through referrals from hospitals, OB/GYNs, WIC and law enforcement, safety fairs, schools, ATV retailers and other campaigns such Arrive Alive, Buckle Up Booster Seats (BUBS), and Back Seat Boss. Bicycle helmet ordinance passed in St. Louis County and development of bike lanes in several cities.

Think First Missouri provided primary prevention interventions regarding head and spinal cord injuries through 67 assemblies and programs to 74 Missouri middle, junior, and high schools. Assemblies and programs provided primary prevention strategies for head and spinal cord injuries.

The Child Care Health Consultation (CCHC) program provided 19 hours of consultation\group education to child care providers regarding motor vehicle safety in young children. In addition, 30 health promotion programs were provided to young children in child care.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MCH regional fall training offered round table discussions with Safe Kids Coordinators from each region providing resources and discussion on best practices to address unintentional injury prevention.				X
2. LPHAs provided home visits to parents of newborns, providing education on car seat safety and referrals for fitting/installation and distribution. LPHAs implemented strategies to reach families with children.		X	X	X

3. Some LPHAs have purchased car seat simulators to use in expanding services offered to families, which include education and decreasing barriers for car seat fittings such as weather conditions.		X	X	
4. LPHAs promoted seat belt use through role modeling of famous people, puppet play and filmstrips. GHC distributes a series of car seat safety cards including safety during pregnancy and safety for premature infants, infants, toddlers, and adolescents.			X	
5. The Missouri Community-Based Home Visiting, Nurse Family Partnership (Building Blocks of Missouri) Home Visiting, and Alternatives to Abortion programs educate clients on the laws related to car seat safety for their newborns and other children.		X	X	
6. Home Visiting Programs provide car seats when no other resources are available. GHC car seat safety cards were distributed.		X	X	
7. Re-establishment of SAFE KIDS Coalition though five county LPHAs in central region. Eight local SAFE KIDS Coalition contracts to provide primary injury prevention interventions for children aged 0-14.			X	X
8. The University of Missouri Think First program provided primary prevention intervention strategies via school assemblies and programs to children and adolescents regarding head and spinal cord injuries.			X	
9. Continued collaboration with the Missouri Division of Highway Safety to assure available training for child passenger safety technicians.			X	X
10. Consultation/education provided to child care providers on motor vehicle safety by the CCHC program.		X	X	

b. Current Activities
Activities listed in Table 4a will be continued.

MCH Coordinated Systems contracts with LPHAs to expand community collaboratives to address motor vehicle crashes by providing data, implementing or expanding evidence-based interventions and evaluation of their current systems to address this issue. Training for Certified Car Seat Installers continues within communities.

The Unintentional Injury Prevention program continues to collaborate with eight local SAFE KIDS Coalitions; School Health Program; Adolescent Health Program, Missouri Injury and Violence Prevention Advisory Committee (MIVPAC), the Missouri Coalition for Roadway Safety, Local Public Health Agencies, public health professionals, and other injury and violence prevention partners to reduce the mortality rate of children aged 0-14 due to motor vehicle crashes.

The Unintentional Injury Prevention program worked to improve and update the website to include current and accurate injury prevention data and resources.

c. Plan for the Coming Year
Activities listed in Table 4a will be continued.

A series of car seat safety cards will educate families on car seat safety. Series includes safety during pregnancy and safety for premature infants, infants, toddlers, and adolescents. Safety cards will be distributed through the DHSS warehouse and at statewide or regional conference exhibits.

The Injury and Violence Prevention Program (IVPP) will partner with seven local Missouri SAFE KIDS Coalitions to provide primary prevention interventions to children aged 0-14. Specific interventions for child passenger safety will include proper car and booster seat installation and proper safety belt use. Other interventions will include rear mirrors on vehicles to prevent children from being run over. The IVPP will also work with the Missouri Injury and Violence Prevention Advisory Committee (MIVPAC) to reduce the mortality rate of children 0-14 due to motor vehicle crashes through education, training, and technical assistance.

The IVPP will continue its partnership with the Missouri Department of Transportation and the Missouri Coalition for Roadway Safety in efforts to reduce the mortality rate.

The IVPP also plans to renew its partnership with Think First Missouri to address injury prevention in adolescents through a social media approach.

The IVPP will continue collaboration with LPHAs, School Health Program, Adolescent Health Program, Missouri Child Fatality Review and other MCH partners to address reducing the mortality rate.

The IVPP will continue to improve and update its website to serve as a resource and link to other resources for prevention activities for this age group.

MCH Coordinated Services LPHA contractors addressing this issue plan to continue/expand evidence based interventions; collect/compile data from community partners, evaluate data, outcomes of interventions implemented and/or system; report back to community partners and local media; continue to advocate for and support environmental and policy changes.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		32	34	34.9	35.1
Annual Indicator	29.9	34.7	30.5	33.0	38.2
Numerator	23235	28229	23957	26846	31279
Denominator	77709	81353	78547	81353	81883
Data Source				National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	38.4	38.6	38.8	39	39.2

Notes - 2009

Breastfeeding percentage is from CDC's National Immunization Survey. 2009 provisional data (2007 birth cohort). 2009 final data will be available in fall 2011. The 2009 denominator is number of 2007 births in Missouri from DHSS Missouri Information for Community Assessment (MICA)-Births, MO Vital Statistics.
2008 data (2006 birth cohort) is updated with final number.

The percent of mothers who breastfed their infants at 6 months of age in Missouri increased from 31.8% in 2003 to 38.2% in 2009 (provisional). Objectives 2010-2014 were based on a combination of trend analysis of data 2003-2009 and discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2008
Breastfeeding percentage is from CDC's National Immunization Survey. 2008 provisional data (2006 birth cohort). 2008 final data will be available in fall 2010. The 2008 denominator is number of 2006 births in Missouri from MICA-Births, MO Vital Statistics.

The percent of mothers who breastfed their infants at 6 months of age in Missouri showed a gradual increase from 2003 to 2008. Although the 2007 data showed a decrease compared with the 2006 data, the decrease was not statistically significant. Objectives 2009-2013 were based on a combination of final data 2003-2006 and discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2007
Breastfeeding percentage is from CDC's National Immunization Survey. 2007 final data are not available yet, and the data collected in 2006 (2004 birth cohort) were used as proxy for 2007 data. 2007 final data will be available in August 2009. Denominator is number of live births in Missouri in 2005.

The percent of mothers who breastfed their infants at 6 months of age in Missouri showed a gradual increase from 2003 to 2006. An annual increase of 0.2% was set to create objectives 2008-2012 based on past performance and discussions with the Section of Healthy Families and Youth, MO DHSS.

a. Last Year's Accomplishments
Breastfeeding was promoted through the AAP champion Dr. Tom Tryon, who presented to healthcare providers on the importance of breastfeeding. In August 2009, Missouri Breastfeeding month promoted the benefits of breastfeeding in an emergency through advertisements in newspaper and magazines, as well as radio spots, and recyclable grocery bags with information on the theme of "Breastfeeding in an Emergency" distributed through healthcare providers to promote the importance of breastfeeding especially in emergencies.

Congress has doubled the WIC funding for the breastfeeding peer counseling program. This will result in doubling the size of the program. In addition, Missouri was one of five state agencies awarded a breastfeeding bonus for the greatest increase in breastfeeding rates. The additional bonus funds will be used to help local WIC agencies implement more evidence based breastfeeding strategies in their clinics.

The Child Care Health Consultation (CCHC) program provided 27 hours of group education to 257 child care providers and parents of children in child care regarding the benefits of breastfeeding and procedures/policies that support breastfeeding families.

New WIC food package guidelines were introduced in 2009, which increased the amount of food provided to mothers who breastfeed their babies full time to better promote and support the establishment of breastfeeding for 12 months. Breastfeeding is also one strategy to address overweight and obesity in children.

MCH Coordinated System contracts with LPHAs addressing obesity prevention as priority health issue included efforts to promote breastfeeding through WIC, prenatal case management, home visits to newborns, and other community/statewide campaigns/promotions.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. LPHAs through MCH Coordinated Systems promoted breastfeeding and provided resources and referrals to lactation experts through prenatal case management and home visits to parents of newborns.		X	X	
2. Breastfeeding is promoted in collaboration with WIC agencies, hospitals, home visiting programs, and Parents As Teachers, Parent Link, and the Missouri Chapter of American Academy of Pediatrics.			X	
3. Breastfeeding evidence-based interventions are provided by the Breastfeeding Peer Counselor programs in WIC, including brochures, posters, and educational materials.		X	X	
4. The Baby Your Baby website and Baby Your Baby Health Keepsake Books provided information for pregnant women, their families, and communities on healthy pregnancies and healthy babies including breastfeeding.			X	
5. The Missouri Community-Based Home Visiting, Nurse Family Partnership (Building Blocks of Missouri) Home Visiting, and Alternatives to Abortion programs educate clients on the importance of breastfeeding and the benefits to mother and infant.		X		
6. Clients who are enrolled in the Alternatives to Abortion program and need a breast pump can get one through the Alternatives to Abortion program if the client is unable to afford one and cannot get one from another source.		X		
7. The SEMO Building Blocks program has a nurse home visitor who is also a certified lactation consultant.	X			
8. CCHC program provided group education to child care providers regarding the benefits of breastfeeding and how to support breastfeeding families in child care.		X	X	
9.				
10.				

b. Current Activities

Activities listed in Table 4a will be continued.

For the first time DHSS required Alternatives to Abortion providers who provided individual or group prenatal and parenting education to their clients and wish to receive reimbursement through the program, to educate on the importance of breastfeeding as one of the mandatory education topics. The Alternatives to Abortion program collects data on breastfeeding initiation.

The State Breastfeeding Coordinator located in the Bureau of Genetics and Healthy Childhood collaborates with the WIC program and the WIC Peer Counselor program to promote breastfeeding. Currently the state breastfeeding coordinator is updating the Lactation Education Curriculum and Lactation Publications for distribution through the State website, this information will be available by end of FY2010. The coordinator is working with Missouri Chapter of AAP to promote breastfeeding in birthing hospitals across the state. On-going breastfeeding promotion is continued through the use of brochures, posters, media, and educational materials.

Missouri WIC is in the process of training all local WIC agency staff (around 850 people) on how to promote and support breastfeeding. Everyone from the WIC clerk to the nutritionist will know basic strategies to be breastfeeding friendly.

WIC local agencies are loaning electric hospital grade breast pumps to participants to continue breastfeeding after they return to work with over 1,800 breast pumps in circulation statewide.

c. Plan for the Coming Year
Activities listed in Table 4a will be continued.

Breastfeeding will be promoted by the state breastfeeding program with the assistance of the American Academy of Pediatrics, breastfeeding champion who will be discussing the Missouri Show Me 5 Steps to assist Missouri hospitals to work toward improving both initiation and duration rates of breastfeeding. The program will be working with other State Agencies to support lactation and review availability of lactation rooms for State Employees and provide literature and educational materials in these lactation rooms along with sign-in sheets which will then be utilized to gather data for the number of women using these lactation rooms in our State Agencies.

DHSS requires Alternatives to Abortion providers who provide individual or group prenatal and parenting education to their clients, to educate on the importance of breastfeeding as one of the mandatory education topics.

MCH Coordinated System contracts with LPHAs addressing obesity prevention plan to continue promote breastfeeding through WIC, prenatal case management, home visits to newborns, local media and other community/statewide campaigns/promotions.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	99	99	99	99	99
Annual Indicator	99.9	96.6	97.2	96.8	93.2
Numerator	78487	78576	79580	78375	73265
Denominator	78547	81353	81883	80944	78631
Data Source				Missouri Newborn Hearing Screening Program	Missouri Newborn Hearing Screening Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**

Annual Performance Objective	99	99	99	99	99

Notes - 2009
Source: Missouri Newborn Hearing Screening Program, DHSS Bureau of Genetics and Healthy Childhood. Final 2009 data for number screened will be available January 2011. Numerator is provisional number of newborns screened before discharge. Denominator is number of 2009 provisional live births as of April 2010 from Birth data, DHSS Vital Statistics. Final birth number for 2009 will be available November 2010.

Numerator and denominator for 2008 are updated with final 2008 data.

The difference between 2008 and 2009 stems from the lack of a specific MOHSAIC report that counted those result forms marked “screened before discharge” in 2009. To be counted, the hospital must mark the box that states “screened prior to discharge.” It is possible that some programs skip that step when filling out the result form. It should be noted that 77,120 MO infants or 98.1% were screened prior to one month of age in 2009 (provisional) - the standard indicator that all state EHDI programs measure success by.

Notes - 2008
Source: Missouri Newborn Hearing Screening Program, DHSS Bureau of Genetics and Healthy Childhood. Final 2008 data for number screened will be available January 2010. Numerator is provisional number of newborns screened before discharge. Denominator is number of 2008 provisional live births from DHSS Vital Statistics. Final birth number will be available October 2008.

Notes - 2007
Numerator number of newborns screened before discharge in 2007 is provisional data, and final data will be available by the end of December 2008. Denominator is number of live births in Missouri in 2007 (provisional data as of June 24, 2008). 2007 final birth data will be available in October 2008.

2008-2012 performance objectives set at 99.0%. There may be annual variations in the percent of newborns who are screened (including indicators > 100.0%) since mothers delivering babies in MO or IL may have their babies screened in MO, or vice versa.

The decrease in the percent of newborns screened prior to discharge since 2006 is due to upgrades implemented in the data management system that allow the system’s reports to accurately reflect the actual number of infants screened prior to discharge.

a. Last Year's Accomplishments
The Missouri Newborn Hearing Screening Program (MNHSP) added four hospitals to the HRSA Loss to Follow-up Pilot Project. Hospitals participating in this project use a script to explain "refer" results to parents, make an appointment for a rescreening or audiologic evaluation for the newborn, and determine who the baby's doctor will be after discharge. The hospital sent that information to the MNHSP and the MNHSP immediately sent a letter to the baby's doctor to inform the doctor of the baby's failure to pass the newborn hearing screening and the need for a rescreening or further testing. MNHSP made reminder calls to the parents twenty-four hours prior to the appointment. First year results were heartening and showed that for the time period 7/1/2008--6/30/2009 a reduction in loss to follow-up rates from 60.2% to 30% occurred for one of the pilot hospitals and a reduction from 68.7% to 32% occurred for another hospital, when compared to the same time frame a year earlier.

To ensure parents of newborns diagnosed with a permanent hearing loss receive unbiased information about early intervention options, the MNHSP continued to collaborate with the Missouri Department of Elementary and Secondary Education (DESE) to implement its MOHear service coordination pilot project in the Kansas City area. The MOHear Project ensures families

of newborns diagnosed with hearing loss have immediate access to the expertise of a professional who is knowledgeable about hearing loss.

The MNHSP distributed a hearing screening training DVD to all birth hospitals. Additionally, the MNHSP distributed parent booklets that describe communication options and lists national and Missouri resources to all pediatric audiologists who evaluate infants.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Loss to Follow-up Pilot Project.			X	
2. MOHear Service Coordination Project.		X	X	
3. Hearing screening DVD mailing to birth hospitals.		X		
4. “Communicate With Your Child” Booklet.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Activities listed in Table 4a will be continued.

Six hospitals participate in the HRSA Loss to Follow-up Pilot Project. Most participating hospitals reduced their rate of loss to follow-up following failure to pass the newborn hearing screening.

The MNHSP is expanding the MOHear service coordination program. Five service coordinators, professionals with expertise in the unique needs of infants with permanent hearing loss, collaborate with the IDEA Part C Program (First Steps) at the initial visit with families of children with recently diagnosed permanent hearing loss. Additionally, the service coordinators have taken on the responsibility of making contact with hospitals and families in areas of high loss to follow-up and conducting rescreenings in order to reduce the rate of loss to follow-up following failure to pass the newborn hearing screening.

The MNHSP mailed updated audiological resource guides to birth hospitals to assist hospitals in finding pediatric audiologists for further testing of newborns who fail to pass the newborn hearing screening. The MNHSP shared results of the last parent satisfaction survey with hospitals and included results of research conducted with Missouri State University that showed the importance of parental anxiety in the likelihood that parents complete recommended follow-up for their infants who failed to pass the newborn hearing screening.

c. Plan for the Coming Year
Activities listed in Table 4a will be continued.

The Missouri Newborn Hearing Screening Program's (MNHSP) MOHear Program, funded by the HRSA grant and operated through a contract with Missouri State University (MSU), will address missed initial hearing screenings by identifying them in the MOHSAIC database, and offering otoacoustic emission (OAE) hearing screening with a portable screener at a mutually agreed upon location. Five screeners, known as MOHears, will cover five regions of the state for this purpose.

The MNHSP, in conjunction with MSU, will continue to loan portable OAE hearing screeners to

three nurses who care for Amish and Mennonite communities and loan one additional OAE screener to another Mennonite community nurse.

The MNHSP, with funding from the CDC Early Hearing Detection and Intervention (EHDI) grant, will build a bridge from the new Vital Records system (MoEVR) to MOHSAIC. This will allow hospitals to electronically enter initial hearing screening results directly into MOHSAIC making reporting easier and allowing for timely follow-up by MNHSP staff.

The Public Health Profile, a database to be used in hospitals, emergency rooms, or physicians' offices, will provide for complete information about hearing and bloodspot screenings, immunizations, allergies, lead and other environmental factors. The profile is still being improved and will include hearing screening and diagnostic evaluation results, risk factors for delayed-onset hearing loss, and audiologist recommendations. It should be fully operational by FY2011 but will continue to be reviewed and improvements made, if necessary.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	8.1	8.2	7.9	10.5	10.4
Annual Indicator	7.7	9.1	10.4	6.8	6.8
Numerator	106000	127000	150454	96051	96051
Denominator	1378232	1398000	1441898	1413974	1413974
Data Source				US Census Bureau. Current Population Survey	US Census Bureau. Current Population Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	6.7	6.6	6.5	6.4	6.3

Notes - 2009
Source: US Census Bureau. Current Population Survey (CPS), Annual Social & Economic Supplement (ASES), 2009. The 2009 survey reflects insurance coverage in 2008. This measure is for children <18 years of age.
Data from the CPS, ASES, 2010 will be available at the end of September 2010.

Annual indicator, numerator and denominator for 2008 are updated with 2008 insurance coverage

data from the CPS, ASES, 2009

The percent of children without health insurance in Missouri showed a gradual increasing trend from 2001 to 2007. However, the percentage decreased from 10.4% in 2007 to 6.8% in 2008. A slight decrease of 0.1% per year was set up for objectives 2010-2014, with considerations of potential policy changes and discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2008
Source: US Census Bureau. Current Population Survey (CPS), Annual Social & Economic Supplement (ASES), 2008. The 2008 survey reflects insurance coverage in 2007. Denominator is population estimate of persons under 18 years of age.
Data from the CPS, ASES, 2009 will be available at the end of September 2009.

The percent of children without health insurance in Missouri showed a gradual increasing trend from 2001 to 2007. In light of potential policy changes and economic factors, it is difficult to make predictions on this measure. Objectives 2009-2013 were based on discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2007
Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2008, Table HI05. The 2008 survey reflects insurance coverage in 2007.

The percent of children without health insurance in Missouri showed a gradual increasing trend from 2001 to 2007. In light of potential policy changes and various environmental factors, it is difficult to make predictions on this measure. Objectives 2008-2012 were set based on discussions with the Section of Healthy Families and Youth, MO DHSS.

a. Last Year's Accomplishments
Special Health Care Needs (SHCN) administered Children and Youth with Special Health Care Needs Program (CYSHCNP) which provides early identification and health services and includes service coordination, diagnostic and treatment services involving medical care, hospitalization and aftercare to participants who require sub-specialty, specialty, preventive and primary care. Medicaid referral, or verification of active enrollment, was required of program participants. The CYSHCNP served 1,259 participants in FY2009.

SHCN also administered the Healthy Children and Youth (HCY) Program through a cooperative agreement with the Department of Social Services MO HealthNet Division (MHD) (Medicaid). The HCY Program implements a portion of Early Periodic Screening, Diagnosis Treatment (EPSDT) requirements, including assessing the need for in-home nursing services (such as personal care, nursing care, and skilled-nursing visits). SHCN staff prior authorized medically necessary in-home nursing services and provided service coordination for participants. 2,613 participants were served through the HCY program in FY2009.

In FY2009, SHCN Service Coordinators completed Service Coordination Assessments (SCA) with participants/families of the CYSHCNP and the HCY Program. The SCA included assessing insurance availability for medical, vision, and dental services. An electronic database was utilized for statewide collection of data. In addition, SHCN maintained standard protocols for Service Coordinators to monitor the status of Medicaid referrals and the ability to obtain participants' Medicaid status through data linkage with Department of Social Services (DSS). Service Coordinators also received training on how to assist potential participants in determining available resources for adequate insurance.

The SHCN Family Partnership Parent and Caregiver Retreat was held November 7-8, 2008 in Columbia, Missouri. The Retreat was attended by 104 parents and caregivers in addition to numerous professionals. A variety of information and resources related to CYSHCN was shared

with the attendees, including a break out session presented by the Missouri Department of Insurance on the Claim and Appeal Process.

The Oral Health Program is aware that many Missouri children do not have access to health insurance. To address increasing access to dental care for uninsured and underinsured Missouri children the Preventive Services Program (PSP) fluoride varnish program expanded capacity and served over 35,000 school children during the 2008-2009 school year.

TEL-LINK included the Medicaid toll free number in the database and provided 166 referrals to Medicaid in FFY 2009. The Department of Social Services has the TEL-LINK toll-free number listed as a childhood resource through the MO HealthNet for Kids (Medicaid) Program website. This allows Missourians access to information on children's health insurance and a direct link to the TEL-LINK website for more information on the TEL-LINK Program.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. SHCN administered the CYSHCNP and the Healthy Children and Youth Program, including Service Coordination.		X		X
2. SHCN Family Partnership Initiative (support network for family members) is used to disseminate information about Medicaid and health insurance availability.		X		X
3. SHCN utilized electronic database for statewide data collection and maintained data link with Department of Social Services to obtain participant Medicaid status.				X
4. SHCN distributed the Insurance Comparison Checklist and the Insurance Fact Sheet and collaborated with other entities. The Autism grant provides materials about possible ways to finance services for children and youth with Autism Spectrum Disorder.		X		X
5. SHCN collaborated with managed care organizations, Systems of Care Boards, DSS, DMH, and DESE to obtain information about CYSHCN that transition within the systems of care.		X		X
6. SHCN collaborated with grant activities including Family to Family Health Information Center, Service Integration, and Improved Services for Children with Autism Spectrum Disorder.		X		X
7. The CCHC provides information to child care providers and parents regarding Medicaid and works with families to locate health care coverage or health care. MOCCRRN provided families who requested child care referrals with Medicaid information.		X	X	
8. Baby Your Baby website and Baby Your Baby Health Keepsake Books include information about financial resources for pregnant women and children, including Medicaid.			X	
9. TEL-LINK included the Medicaid toll free number in the database and provided referrals as requested.			X	
10. School Health Services contracts and MCH contracts with LPHAs require uninsured children to be referred to Medicaid.		X		

b. Current Activities

Activities listed in Table 4a will be continued.

SHCN is enhancing the statewide database to improve claims processing and payment for services. The Family Partnership Parent and Caregiver Retreat was held in December 2009 and

provided parents with information on how to apply for Medicaid. The service integration grant and the grant to establish a Family to Family Health Information Center are developing resource packets related to insurance and health care financing. Plans for sustainability of the Family to Family Health Information Center are underway as grant funding will end in 2010.

Council for Adolescent and School Health is working with the Missouri Primary Care Association on strategies to increase adolescent enrollment in Medicaid through the Teen Enrollment Effort Now project.

The Adolescent Health Program, Adolescent Medicine Consultant, Missouri American Academy of Pediatrics, and national colleagues are exploring replication of Bright Futures toolkit with health providers that serve adolescents.

Parent Central was added to MOCCRRN's website to provide resources and information to families.

The Pew Center on the States released a "grade card" which indicated Missouri failed to meet the benchmark that measured Medicaid enrolled children which received dental care. Increasing access to oral health care for is being addressed through initiatives with FQHCs. The Preventative Services Program has expanded and served 49,000 children thus far in the 2009-2010 school year.

c. Plan for the Coming Year
Activities listed in Table 4a will be continued with the exception of the Family to Family Health Information Center grant which is to end in 2010.

CASH will work with the MO Primary Care Association and other partners on strategies to increase adolescent enrollment in Medicaid through the Teen Enrollment Effort Now (TEEN) project.

AHP, Adolescent Medicine Consultant, Missouri AAP, and national colleagues will explore replication of Bright Futures toolkit with health providers that serve adolescents.

The School Health Services Program has a performance measure to increase the percent and number of school-age children with an identified health care provider. Nurses and Social workers in school districts will receive training on Medicaid enrollment.

The Oral Health Program (OHP) will continue to collaborate with the Office of Primary Care and Rural Health (OPCRH) in effort to increase access to dental and medical primary care through increased Federally Qualified Health Center (FQHC) access. Additionally the OPCRH has health professional loan and loan repayment programs that increase access to healthcare in underserved areas and for vulnerable populations.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		30	30	30	30.7
Annual Indicator	30.4	30.2	30.3	30.7	30.7
Numerator	17506	16182	16665	18699	18699
Denominator	57587	53585	55001	60908	60908

Data Source				Pediatric Nutritional Surveillance System	Pediatric Nutritional Surveillance System
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	30.6	30.6	30.5	30.5	30.4

Notes - 2009
Source:CDC data tables from 2008 Pediatric Nutritional Surveillance System. 2008 numbers being used as a proxy for 2009. The 2009 numbers will not be available until Fall 2010.

WIC has implemented the new WIC food package since October 2009. We anticipate a gradual decrease in the overweight rate among WIC children.

Notes - 2008
Source:CDC data tables from 2008 Pediatric Nutritional Surveillance System.

The 2008 data showed a slight increase in this measure compared with the 2007 data, though the increase was not statistically significant. Missouri WIC program has made some changes in the food package to provide healthier foods since 2002, and will implement the new WIC food package in October 2009. We expect to see a gradual decrease in the overweight rate among WIC children with our new food package and getting children more into physical activity.

Notes - 2007
Source: CDC. Data Tables of the Pediatric Nutrition Surveillance System (PedNSS), Missouri.

Although Missouri is being affected by the same social and demographic factors contributing to childhood obesity as the rest of the nation. As reducing obesity among children is a stated priority of the state, we intend to make every effort to make progress in this performance measure.

a. Last Year's Accomplishments
The revised food packages add new food categories and offer optional substitutions for some of the current foods. The changes are intended to better meet the needs of the wide range of WIC clients. Under the new rules:
-WIC clients can purchase whole grains and fresh and frozen fruits and vegetables.
-Beginning at 6 months, all infants receive infant fruits and vegetables. Infants who do not obtain formula from WIC will also receive infant meats.
-Soy milk and tofu may be given as an alternative to milk, with medical documentation.
-Canned beans are offered as an alternative to dry beans.
-The amount of milk, eggs, juice and cheese is reduced for women and children.
-Juice is eliminated for infants.
-The amount of infant formula is reduced for partially breastfed and older infants.

The new food packages are lower in fat and cholesterol, higher in fiber and limit added sugar and sodium. These new options help WIC participants improve their diet and maintain a healthy weight.

The Child Care Health Consultation (CCHC) program used consultation and education opportunities to inform child care providers and parents of children in child care regarding WIC services. CCHC provided 240 hours of group education to child care providers and parents of children in child care regarding nutrition and 67 hours of regarding physical fitness/wellness. In addition, CCHC provided 197 health promotion programs regarding nutrition and 53 programs related to physical activity/exercise to young children in child care.

LPHAs addressing obesity prevention as their priority health issues through MCH Coordinated Systems contracts, collaborated with WIC programs (majority of which are located in LPHAs) to provide nutritional education/healthy choices, provision of coupons to parents for fresh fruits/vegetables from area grocers and farmer's markets and promoted physical activity such as Fit WIC. Programs/education involving child care providers, Head Start, and Parents as Teachers were implemented.

Missouri Eat Smart Guidelines for Child Care are a set of voluntary nutrition standards for child care centers and homes that encourage providers to improve the nutrition of their menus and the environment in which meals are consumed. Child care providers participating in the Child and Adult Care Food Program can apply for recognition as a Missouri Eat Smart Child Care. The Team Nutrition Program is also working on a pilot initiative to assist a group of centers in meeting the Guidelines.

The DHSS is a member of an interdepartmental committee that is working on encouraging communities to get their children into nature. The Children in Nature Challenge Program has a website and a recognition program is being developed.

Offered through the WIC program, Fit WIC provides programs for WIC families to increase their physical activity and improve nutrition habits.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The CCHC program provides information to child care providers and parents of children in child care regarding WIC, nutrition, and physical activity.		X	X	
2. LPHAs addressed obesity prevention through improved nutrition and physical activity interventions through WIC eligible families and other programs serving young children.		X	X	
3. Family fun night events and health fairs promoted by LPHAs and community partners incorporate activities around healthy snacks and physical activity for all ages.		X	X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Activities listed in Table 4a will be continued.

Increase outreach by LPHAs to child care providers is resulting in environmental and policy change around nutritious meals/snacks, decrease use of sweetened juices, screen time, and

physical activity. LPHAs continue to work with WIC eligible families to promote better nutrition and physical activity for small children. BMI data is being collected and results evaluated to determine effectiveness of interventions.

The Child Care Health Consultation (CCHC) program works in close cooperation with the Section for Child Care Regulation (SCCR) staff regarding the health and safety of children in child care. The CCHC program also works with the Bureau of Community Food and Nutrition Assistance Program in addressing obesity prevention among young children in child care.

c. Plan for the Coming Year
Activities listed in Table 4a will be continued.

BHI will continue to produce data for children ages 2-5 years receiving WIC services with a BMI at or above the 85th percentile for this measure and provide it online via the WIC Child MICA, http://www.dhss.mo.gov/WICMICA/index.html . BHI will continue to provide data for children aged 2-5 years at or above the 95th percentile on the Child Health Community Data Profile, http://www.dhss.mo.gov/CommunityDataProfiles/.

MCH Coordinated Services LPHA contactors will continue to refer eligible families with young children to WIC and evaluate programs implemented such as Fit WIC.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		17	19	19.6	18
Annual Indicator	17.7	20.4	18.4	21.4	21.4
Numerator	13940	16591	15066	17322	16827
Denominator	78549	81353	81883	80944	78631
Data Source				Missouri PRAMS	Missouri PRAMS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	20.5	20	19.5	19	18.5

Notes - 2009
The 2009 estimated percentage of maternal smoking during the last 3 months of pregnancy is not available yet. The 2008 estimate based on the 2008 Missouri PRAMS survey response is used as proxy for 2009. 2009 PRAMS data will be available January 2011. Denominator is estimated using the number of live births in Missouri, provisional 2009, as of April 2010. 2009 final birth data will be available in November 2010. from DHSS Mo Vital Statistics.

A gradual decrease in maternal smoking rate during the last 3 months of pregnancy was set up

for objectives 2010-2014, based on discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2008
The 2008 estimated percentage of maternal smoking during the last 3 months of pregnancy is not available yet. The 2007 estimate based on the 2007 Missouri PRAMS survey response is used as proxy for 2008. 2008 PRAMS data will be available January 2010. Denominator is estimated using the number of live births in Missouri, provisional 2008, as of April 2009. 2008 final birth data will be available in October 2009.

A gradual decrease in this measure over the next five years 2009-2013 is expected, with considerations of a slight decrease in smoking during pregnancy for two consecutive years 2007-2008 observed from the birth file, and discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2007
Missouri has participated in the Pregnancy Risk Assessment Monitoring System (PRAMS) since 2007. 2007 estimate of smoking during last 3 months of pregnancy from PRAMS is expected to be available by the end of December 2008. An estimated percent from the Missouri's pilot PRAMS survey (2005-2006 Missouri Pregnancy Related Assessment and Monitoring System, MoPRA) was used as a proxy for 2007. Denominator is estimated using the number of live births in Missouri in provisional 2007 as of April 28, 2008. 2007 final birth data will be available in October 2008.

Despite limited funding for tobacco prevention and cessation programs in Missouri, we intend to make every effort to make progress in this measure. An annual decrease of 0.4% was used to create objectives 2008-2012, with consideration of trend analysis on the measure smoking during pregnancy from the birth file and discussions with the Section of Healthy Families and Youth, MO DHSS.

UPDATE: 2007 data have been updated using the 2007 Missouri PRAMS data.

a. Last Year's Accomplishments
MCH Coordinated Systems provided regional fall trainings for LPHAs contractors with round table discussions on tobacco cessation/prevention to include regional Community Policy Experts from DHSS Comprehensive Tobacco Prevention Program. Evidence based interventions/best practices and resources were presented. LPHAs screened and provided cessation programs/support to pregnant women continuing to smoke, along with risks of second hand smoke for infants and children.

The Missouri Community-Based Home Visiting, Nurse Family Partnership (Building Blocks of Missouri) Home Visiting, and Alternatives to Abortion programs educate their clients on not smoking during pregnancy and the dangers of second hand smoke. Women were assisted in quitting smoking using the 5As and referred to smoking cessation programs and the Missouri Tobacco Quitline if interested. In 2009, 12% of women enrolled in the Building Blocks Program quit smoking from intake to 36 weeks of gestation.

Smoking cessation educational cards targeted young moms and dads with information about the dangers of tobacco use and secondhand smoke to unborn babies. Baby Your Baby website (http://www.dhss.mo.gov/babyyourbaby), Baby Your Baby Health Keepsake Books, and educational brochures in English, Spanish, Vietnamese, and Chinese provided information about smoking cessation during pregnancy. Educational materials on smoking cessation (28,456) were distributed were distributed through the DHSS warehouse and at statewide conference exhibits.

Since the start of the Missouri Tobacco Quitline in 2005, the priority population has been adults (over age 18) on Medicaid or who are uninsured and pregnant women, regardless of insurance

status. At this time, all individuals that call can receive materials and/or one coaching call to assist them in setting up their plan. The priority populations may enroll in multiple coaching calls and receive nicotine replacement therapy (NRT). Currently, individuals with chronic diseases, women breastfeeding an infant under one year of age, and women planning to get pregnant in the next three months are part of the priority population.

From July 2008 to June 2009, 124 pregnant women requested an intervention through the Quitline. Seven pregnant women received nicotine replacement therapy. Interventions are an intensive telephone-based program. The callers will receive specialized materials, a Quit Kit, and a series of three calls with the same specialist during a three to four month period. The timing of the calls will be based upon the caller's quit date and availability. Quit Coaches will work with callers to determine their readiness to quit, discuss their options for using nicotine replacement products or other cessation aids, assist them in developing an individually-tailored quit plan and schedule up to four follow-up sessions designed to enhance motivation and facilitate behavior change.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. LPHAs provide education and referrals related to tobacco use to pregnant women through prenatal case management, health fairs, referrals to Quit Line and other community events.		X	X	
2. The Missouri Community-Based Home Visiting, Nurse Family Partnership (Building Blocks of Missouri) Home Visiting, and Alternatives to Abortion programs educate their clients on not smoking during pregnancy.		X	X	
3. Baby Your Baby website, Baby Your Baby Health Keepsake Books, and educational brochures\cards provided information about smoking cessation during pregnancy and the dangers of tobacco use and secondhand smoke.			X	
4. Missouri Tobacco Quitline provides information and assistance for smoking cessation.	X	X		
5. American Lung Association's Freedom from Smoking cessation program and MO Model for Brief Smoking Cessation were provided by a number of LPHAs.		X	X	
6. Smoke Free Dining Guides have been developed and distributed within communities.			X	
7. CCHC group education to child care providers on the dangers of second hand smoke and environmental triggers for asthma in the child care setting.		X		
8.				
9.				
10.				

b. Current Activities

The activities listed in Table 4a will be continued.

For the first time, DHSS required Alternatives to Abortion providers who provided individual or group prenatal and parenting education to their clients to educate on the risks of smoking during pregnancy as one of the mandatory education topics.

c. Plan for the Coming Year

The activities listed in Table 4a will be continued.

Bureau of Health Informatics (BHI) will continue to provide the data for this measure from the vital records system, and distribute it on the Internet via the Birth MICA module. In January 2010, BHI launched a web-based birth registration system that captures the number of cigarettes/packs of cigarettes smoked per day during the "third trimester of pregnancy" (National Center for Health Statistics terminology). These data are being collected in 2010 and will be available for analysis in 2011. The Birth MICA module will be redesigned to incorporate this new data.

MCH Coordinated Systems LPHA contractors addressing tobacco prevention/cessation plan to continue offering cessation classes and prevention messages through collaboration with WIC, school nurses, prenatal case management, home visitation, worksite wellness programs and other community partners; advocate and support smoke free policy changes within communities; and evaluate programs and systems developed during contract period.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	7.9	5.9	5.3	8	9.5
Annual Indicator	6.5	8.5	8.5	11.6	8.0
Numerator	27	35	35	48	33
Denominator	416034	412208	414182	412660	412660
Data Source				MO DHSS. Vital Statistics	MO DHSS. Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	8	7.9	7.7	7.6	7.4

Notes - 2009
Source: DHSS Vital Statistics. Numerator is provisional 2009 death number of persons age 15 through 19 years as of April 2010. Final number will be available November 2010. The 2008 population estimate of persons age 15-19 years is used as proxy for 2009. The 2009 population number will be available November 2010.

The increase in MO's teen suicide rate observed in 2008 did not continue in 2009. The teen suicide rate decreased from 11.6 per 100,000 in 2008 to 8 per 100,000 in 2009 (provisional). Objectives for 2010-2014 were based on trend analysis of data 1999-2009 and discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2008

Source: DHSS Vital Statistics. Numerator is provisional death number of persons age 15 through 19 years as of April 2009. Final number will be available November 2009. The 2007 population estimate of persons age 15-19 years is used as proxy for 2008. The 2008 population number will be available November 2008.

The teen suicide death rate increased in 2008 compared with that in 2007. However, this increase was not statistically significant. The teen suicide deaths were geographically dispersed. A majority of the deaths were among ages18-19 years, males, and whites. About half of the deaths were by discharge of firearms.

Since 2004, there has been an ongoing controversy over whether antidepressant medications might reduce or increase suicide risk in children and adolescents. There is a wide range of factors that might lead to suicide. Considering the small number of deaths and possible fluctuation for one-year data, it is too early to say this is a start of a real increase. Objectives 2009-2013 were based on the three-year (2006-2008) average rate of 9.5 per 100,000 and discussions with the Section of Healthy Families and Youth, DHSS.

Notes - 2007
Source: Missouri Information for Community Assessment (MICA) Death, and Bureau of Health Informatics, MO DHSS. 2007 provisional death data as of April 28, 2008. 2007 final death data will be available in November 2008. 2007 denominator of population estimate 15-19 years of age is not available yet, and 2006 population estimate is used as a proxy for 2007. 2007 population estimate for specific age groups will be available in November 2008.

Future objectives 2008-2012 were based on trend analysis on data 1999-2007 and discussions with the Section of Healthy Families and Youth, MO DHSS.

a. Last Year's Accomplishments
MCH Coordinated Systems District Nurse Consultant participated in the Missouri Suicide Prevention Advisory Committee to review Missouri's data, best practices to address suicide prevention and to develop policy around this issue. MCH regional staff provided consultation and resources to schools and LPHAs to address suicide prevention through efforts such as bullying programs.

LPHA contractor with injury prevention as priority health issue conducted assessment with community partnership to identify gaps in suicide prevention.

The State School Nurse Consultant is a certified Olweus Bullying Prevention Program (OBPP) Trainer. The School Health Program facilitated implementation of the OBPP in four rural school districts reaching 1,558 students and 199 staff.

Several Teen Outreach Program (TOP) clubs received suicide prevention mini-grants for community awareness projects.

The School Health Program received the Governor's Award for Innovation related to work across disciplines to address the mental health needs of children. Bright Futures in Practice: Mental Health is used as a foundation for all trainings with schools, public health, and mental health providers. This collaboration initiated with MCH funds is now supported with funds from local and state agencies and foundations. Fifteen agencies actively participate in the Missouri Show Me Bright Futures collaboration.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implementation of the Olweus Bullying Program and Bullying			X	X

and Violence Program through the School Health Program and LPHAs.				
2. LPHA conducted community partnership assessment to identify gaps in suicide prevention programs and collaborated with school nurses to provide education information and in-services to school staff on topic.			X	
3. LPHAs participated in School Health Advisory Committees to address health/safety issues and referral system for issues such as suicide.		X		X
4. A Public Health Consultant Nurse from the Bureau of Genetics and Healthy Childhood serves on the State Child Fatality Review Team. Suicide of children under the age of 18 is one of the topics addressed by the Team.				X
5. District Nurse Consultant/CASH member serves on the state Suicide Prevention Advisory Committee.				X
6. State Adolescent Health Coordinator serves on Governor's Substance Abuse Prevention Advisory Committee and Missouri Youth/Adult Alliance to address substance use and mental health conditions linked to suicide prevention.			X	X
7. The state school nurse consultant assures that Mental Health promotion and suicide prevention\awareness programs are offered in state and regional conferences for school staff.			X	X
8. CASH promotes appropriate physical and mental health services to meet the needs of adolescents through its member organizations, networks, and partners.			X	X
9. TOP contractors are addressing bullying prevention. Two TOP Clubs received mini-grants for suicide prevention activities in Phelps County which is also a Bright Futures in Mental Health county.	X		X	
10. The Bright Futures Mental Health Collaborative meets quarterly.			X	X

b. Current Activities
Activities listed in Table 4a will be continued.

MCH Coordinated Services staff, with the School Health Program, Children's Trust Fund, Department of Mental Health, Department of Elementary and Secondary Education, Missouri Foundation for Health, and Georgetown University is piloting the Bright Futures in Mental Health public health model for building mental health resiliency in three communities.

The School Health Program co-sponsors professional development sessions for school nurses, school social workers, and school staff on Identifying Warning Signs of Suicide and supports webinars on suicide prevention.

Recent research identified TOP as an intervention that fosters emotional well-being. Phelps County was selected as a Bright Futures in Mental Health site; the TOP is among the strategies to be evaluated.

c. Plan for the Coming Year
Activities listed in Table 4a will be continued.

Based on results from website user survey, emotional and mental health including suicide, and substance use prevention related resources will be added to revise the Adolescent Health

webpage.

Mental Health Promotion will be a focus for the staff in the school health services program. The state school nurse consultant will partner with the Department of Mental Health to offer "Mental Health First Aid" for school nurses and school staff in regional settings.

The State School Nurse Consultant is a certified Olweus Bullying Prevention Program (OBPP) Trainer and plans to partner with others to offer the OBPP program in three additional rural school districts.

MCH Coordinated Systems staff will partner with DMH and other partners to provide ongoing technical assistance and consultation on public health model of mental health resiliency to three Show Me Bright Futures pilot communities; LPHA contractors addressing injury prevention; and schools in determining/implementation of evidence based interventions.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	80.2	80.6	80.9	77	78.5
Annual Indicator	77.6	73.1	76.2	81.1	78.7
Numerator	880	825	893	886	909
Denominator	1134	1128	1172	1092	1155
Data Source				MO DHSS. Vital Statistics	MO DHSS. Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	79.2	79.7	80.2	80.7	81.2

Notes - 2009
Source: DHSS Vital Statistics. Denominator is very low birth weight (VLBW) infants born to Missouri residents and delivered in Missouri, provisional data as of May 2010. Numerator is VLBW infants delivered at Level III Missouri hospitals. Final 2009 numbers will be available November 2010. Very low birth weight (VLBW) defined as less than 1500 grams birth weight.

Numerator and denominator for 2008 are updated with 2008 final data.

There are multiple factors at play in this indicator such as competitive admission practices among hospitals and inappropriate admission based on insurance status. A modest improvement of 0.5% in this measure is set up for objectives 2010-2014, based on discussions with the Bureau of Health Informatics and the Section of Healthy Families and Youth, MO DHSS.

Notes - 2008

Source: Missouri Information of Community Assessment (MICA). DHSS Vital Statistics. Denominator is very low birth weight (VLBW) infants born to Missouri residents and delivered in Missouri, provisional data as of April 2009. Numerator is VLBW infants delivered at Level III Missouri hospitals. Final numbers will be available November 2009.

From 1990 to 2005, the percent of VLBW infants delivered at level III hospitals had fluctuated around 78%. There was a noticeable decrease from 77.6% in 2005 to 73.1% in 2006 (p=0.01), but the decrease did not continue in 2007. MO had seen an increase for two consecutive years 2007-2008. Several complex issues might limit improvement in this measure, including inappropriate admission based on insurance status or due to competitive admission among hospitals, and increase in Newborn Intensive Care Unit beds in both level II and III hospitals over years.

An annual increase of about 0.5% was set to create objectives for 2009-2013, based on data in the last 3 years, long-term trend in the past 10 years and discussions with the Bureau of Health Informatics and the Section of Healthy Families and Youth, MO DHSS.

Notes - 2007
Source: Bureau of Health Informatics, DHSS. Birth Data. Denominator is the number of VLBW infants to Missouri residents delivered in Missouri; numerator is the number of VLBW infants to Missouri residents delivered in Level III hospitals in Missouri. 2007 birth data are provisional, and 2007 final birth data will be available in October 2008.

An annual increase of about 1% was set to create future objectives for 2008-2012, based on discussions with the Bureau of Health Informatics and the Section of Healthy Families and Youth, MO DHSS.

a. Last Year's Accomplishments
Missouri designates three levels of care. Hospitals are surveyed annually regarding the services they provide and the experience and training of their medical staff. Level of Care designations are made every year by DHSS for statistical purposes using the prior year's birth and fetal death records, and the most recent hospital survey results (2009 designations will use 2008 hospital survey results). Infant death and hospital discharge data are also used to support the designations. The criteria for distinguishing between the levels of care are based on guidelines from a 1986 survey of perinatal care by the National Institute of Child Health and Human Development, the 1994 DHSS "Show Me Buyer's Guide: Obstetrical Technical Report", and the 2004 ‘Levels of Neonatal Care' Policy Statement by the American Academy of Pediatrics. Briefly, Level I hospitals provide services for uncomplicated maternity and newborn cases as evidenced by having a well-newborn nursery. They have the ability to stabilize unexpected problems, provide neonatal resuscitation, and have mechanisms in place to initiate maternal and neonatal transports when needed. Level II hospitals have Level I functionality, plus provide services for selected problems such as pre-eclampsia and premature labor at 32 weeks and later. Level II hospitals must have a chief of obstetrical services that is board-certified, or at least two active/associate obstetrical staff that are board-certified. A lab technician is available in-house 24-hours a day and anesthetist services are available 24-hours a day in a Level II hospital. As a general rule they deliver more than 500 infants per year and have organized programs to initiate and accept maternal-fetal and neonatal transports. Level III facilities have the functionality of Level II hospitals. They have the capacity to treat most serious maternal illnesses and abnormalities. Level III hospitals must be able to care for medically-fragile neonates in a Neonatal Intensive Care Unit (NICU) separate from their well-newborn nursery. Level III hospitals have an organized program to accept and direct transport of high-risk mothers and neonates.

For 2008 the designations of several hospitals were changed from 2007, resulting in the number of Level III hospitals increasing from 11 in 2007 to 12 in 2008. Among the changes, one 2007 Level III hospital in St. Louis was re-designated as Level II. Two Level II hospitals, one in Joplin and one in Cape Girardeau, were designated for the first time as Level III. Aside from the Level III

hospitals in Joplin and Cape Girardeau, there are two in Springfield, two in Columbia, three in Kansas City and three in St. Louis. With the 2008 designations, some women in northern and south central Missouri had to travel up to 120 miles to reach the nearest Level III hospital.

Very Low Birth Weight (VLBW, less than 1500 g) is the denominator for this indicator because of its close relationship to premature births and infant mortality. VLBW infants are closely associated with very preterm births. In 2008, 47% of infant deaths in Missouri were VLBW. The American Academy of Pediatrics reported in 2004 that most studies that link neonatal outcomes with levels of perinatal care indicate that morbidity and mortality for VLBW infants are improved when delivery occurs in a Level III facility rather than a Level I or Level II facility.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Home Visiting and Alternative to Abortion programs educated clients on need for early entry into and adequate prenatal care.		X		
2. Education about the impact of alcohol, tobacco and other drug exposure on pregnancy and interventions to assist in cessation.		X	X	
3. Genetic tertiary centers provided genetic screening, counseling, medical referral and outreach.		X	X	
4. TEL-LINK connected callers to LPHAs, prenatal clinics, pediatric and delivering hospitals.			X	X
5. BHl provided data needed to produce this measure. Birth weight and place of birth are collected through the vital statistics system. Level of care data is collected through the Annual Hospital Licensing Survey of Missouri Hospitals.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Activities listed in Table 4a will be continued.

In the FY 09 legislative session, the General Assembly passed the law RSMo 191.711.1 which requires the Department of Health and Senior Services to develop educational materials to be distributed to parents of premature infants by healthcare providers to provide standardized care. Medimmune a pharmacological company donated relevant materials and the department in collaboration with hospital neonatal intensive care units, as well as other birthing hospitals adapted these materials and made it available via the web to all providers at hospitals that provide care to high-risk premature and very low birth weight infants.

c. Plan for the Coming Year
Activities listed in Table 4a will be continued.

BHI is currently developing an improved standardized scoring rubric to more accurately determine neonatal levels of care in hospitals.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	86.8	87	87.3	84.6	84
Annual Indicator	86.0	84.7	84.1	83.8	84.2
Numerator	67571	68919	68863	67844	66174
Denominator	78547	81353	81883	80944	78631
Data Source				MO DHSS. Vital Statistics	MO DHSS. Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	84.4	84.6	84.8	85	85.2

Notes - 2009
Source: Missouri Information for Community Assessment (MICA)-Births, DHSS Vital Statistics. Provisional 2009 data as of April 2010. Final 2009 data will be available November 2010.

Numerator and denominator for 2008 are updated with 2008 final data. The proportion of early prenatal care in Missouri has been consistently above the national level. Mirroring the national trend, the percentage in this indicator in Missouri had shown a small but noticeable decline for three consecutive years 2006-08. However, MO's 2009 provisional data showed a slight increase compared with the 2008 data. Hopefully this is the start of further improvement in this measure.

An annual increase of 0.2% is used to create objectives 2010-2014, based on the general increasing trend 1990-2009 and discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2008
Source: Missouri Information for Community Assessment (MICA)-Births. DHSS Vital Statistics. Provisional 2008 data as of April 2009. Final data will be available November 2009.

The proportion of early prenatal care in Missouri has been consistently above the national level. Since 2006, the percentage in Missouri had shown a small but noticeable decline and the decline had continued for three consecutive years 2006-08. The decline was slightly larger in Medicaid population than in non-Medicaid population. A similar decline had been observed in the national data in 2005 and 2006. More recent changes to welfare and Medicaid policy might limit further improvements in timely care. Some MO hospitals have shifted from using self-reported information by the mother to using electronic medical records to collect prenatal care information for the birth certificate. It was reported that there had been a decline in early prenatal care following the implementation of a revised birth certificate that uses electronic prenatal care records.

An annual increase of 0.2% is used to create objectives 2009-2013, based on general increasing trend 1990-2008 and discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2007

Source: Missouri Information for Community Assessment (MICA) - Birth, and Bureau of Health Informatics, MO DHSS. 2007 provisional data as of April 28, 2008. 2007 final birth data will be available in October 2008.
There has been a slight decrease in the percent of prenatal care in the 1st trimester since 2006. It has been not clear why the number goes down. Some potential factors are speculated such as limited access to care and capacity of delivering doctors, and changes in prenatal care data collection from using self-reported information by the mother to using electronic medical records. An annual increase of 0.5% is used to create objectives 2008-2012, based on discussions with the Section of Healthy Families and Youth, MO DHSS.

a. Last Year's Accomplishments
The Missouri Community-Based Home Visiting program served 815 families, Nurse Family Partnership (Building Blocks of Missouri) Home Visiting program served 446 families, and Alternatives to Abortion program served 1,641 women and educated their clients on the importance of early entry into and adequacy of prenatal care for subsequent pregnancies. Clients are assisted with finding a prenatal care provider if they do not have one when enrolling in the program and on applying for Medicaid to have a payment source for prenatal care. Of the women enrolled in Missouri Community-Based Home Visiting, 36% reported entering prenatal care during the 1st trimester. Eighty-four percent of the women enrolled in the Building Blocks Program and 63% of the women enrolled in Alternatives to Abortion reported entering prenatal care in the 1st trimester.

TEL-LINK referred callers to prenatal care as requested and included the referral in newsprint advertising. The importance of regular and early prenatal care was promoted through a thirty-second radio spot which aired in St. Louis. Brochures on prenatal care were distributed at various conferences and health fairs.

Safety net providers such as FQHCs provide many services to pregnant women in low income and underserved areas of the state. FQHCs have primary and satellite locations across Missouri and are charged with treating vulnerable populations. The Office of Primary Care and Rural Health assists FQHCs with oral health educational materials for pregnant women.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Missouri Community-Based Home Visiting, Nurse Family Partnership (Building Blocks of Missouri) Home Visiting, and Alternatives to Abortion programs educate their clients on the importance of early entry into and adequacy of prenatal care.		X	X	
2. TEL-LINK referred callers to prenatal care as requested.			X	
3. Baby Your Baby website and Baby Your Baby Health Keepsake Books provided information for pregnant women, their families, and communities on healthy pregnancies and healthy babies which include the topic of prenatal care.			X	
4. DHSS requires Alternatives to Abortion providers who provide individual or group prenatal and parenting education to their clients to educate on the importance of prenatal care as one of the mandatory education topics.		X	X	
5. FQHCs provide safety net services.	X			
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Activities listed in Table 4a will be continued.

For the first time, DHSS requires Alternatives to Abortion providers who provide individual or group prenatal and parenting education to their clients to educate on the importance of prenatal care as one of the mandatory education topics. The program is collecting data on when the clients enter prenatal care.

The OPCRH assists FQHCs with oral health educational materials for pregnant women. Currently, the OPCRH is providing funding to 8 dentists to serve in designated health professional shortage areas (HPSA).

c. Plan for the Coming Year
Activities listed in Table 4a will be continued.

Prenatal care will be listed as a referral in TEL-LINK advertisement.

Efforts to promote Text4baby, a national campaign to promote maternal and child health through free text messages to pregnant women and new moms, includes messages about the importance of early and regular prenatal care.

D. State Performance Measures

State Performance Measure 1: *Percent of women who have reported smoking during pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	17.5	16.3	14.4	16.5	17.3
Annual Indicator	18.2	18.4	17.7	17.6	16.8
Numerator	14317	14946	14534	14212	13200
Denominator	78547	81353	81883	80944	78631
Data Source				MO DHSS. Vital Statistics	MO DHSS. Vital Statistics
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	17.1	17	16.8	16.7	

Notes - 2009
Source: Missouri Information for Community Assessment (MICA)-Births, DHSS Vital Statistics. Provisional 2009 live births number as of April, 2010. Final data will be available, November, 2010. Numbers for 2008 have been updated with final data.

MO had seen a small but continuing decrease in maternal smoking for three consecutive years 2007-2009.

Notes - 2008

Source: Missouri Information for Community Assessment (MICA)-Births. DHSS Vital Statistics. Provisional 2008 live births number as of April, 2009. Final data will be available, November, 2009.

Since 2007 MO had seen a small but continuing decrease in maternal smoking for two consecutive years 2007-2008. Objectives 2009-2013 were based on trend analysis on data 1994-2008, and discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2007
Source: Missouri Information for Community Assessment (MICA)- Births
and the Bureau of Health Informatics, MO DHSS. 2007provisional data as of April 28, 2008. 2007 final birth data will be available in October 2008.

Despite limited funding for tobacco prevention and cessation programs in Missouri, we intend to make every effort to make progress in this measure. Objectives 2008-2012 were set with considerations of trend analysis on data 1990-2007, and discussions with the Section of Healthy Families and Youth, MO DHSS.

a. Last Year's Accomplishments
MCH Coordinated Systems provided regional fall trainings for LPHAs contractors with round table discussions on tobacco cessation/prevention to include regional Community Policy Experts from DHSS Comprehensive Tobacco Prevention Program. Evidence based interventions/best practices and resources were presented. LPHAs screened and provided cessation programs/support to pregnant women continuing to smoke, along with risks of second hand smoke for infants and children. Increased number of LPHAs sent RNs/Health Educators for training on cessation programs such as American Lung Association's Freedom from Smoking, and MO Model for Brief Smoking Cessation then promoted programs through WIC and other services for pregnant women.

The Missouri Community-Based Home Visiting, Nurse Family Partnership (Building Blocks of Missouri) Home Visiting, and Alternatives to Abortion programs educate their clients on not smoking during pregnancy. Thirty-six percent of women enrolled in the Missouri Community-Based Home Visiting Program and 17% of women enrolled in the Building Blocks Program reported a history smoking during pregnancy.

Approximately 3,000 smoking cessation educational cards were distributed to young moms and dads with information about the dangers of tobacco use and secondhand smoke to unborn babies. The cards were distributed to health care providers, Parents as Teachers educators, managed care health plans, and Missouri citizens upon request. In FFY2009, 28,456 brochures related to smoking cessation were distributed in addition to the Baby Your Baby material.

From July 2008 to June 2009, 124 pregnant women requested an intervention through the Missouri Tobacco Quitline. Seven pregnant women received nicotine replacement therapy. Interventions are an intensive telephone-based program. The callers will receive specialized materials, a Quit Kit, and a series of three calls with the same specialist during a three to four month period. The timing of the calls will be based upon the caller's quit date and availability. Quit Coaches will work with callers to determine their readiness to quit, discuss their options for using nicotine replacement products or other cessation aids, assist them in developing an individually-tailored quit plan and schedule up to four follow-up sessions designed to enhance motivation and facilitate behavior change.

A 2007 County Level Study found 82% of Missourians who work indoors are now protected from smoking in their work areas and 63.5% would support a smoke-free restaurant law. Efforts to establish local smoke-free policies are getting increasing support, starting with Missouri's first smoke-free restaurants ordinance in Maryville.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. LPHAs developed tobacco campaigns, using branding of logo to unite all Missouri communities advocating for smoke-free environments.			X	X
2. LPHAs developed worksite initiatives to promote tobacco cessation/prevention and provided education/referrals to women in WIC and through prenatal case management.			X	
3. Missouri Tobacco Quitline provides materials and/or coaching telephone call. The priority population is adults (over age 18) on Medicaid or uninsured and pregnant women regardless of insurance status.		X		
4. The Missouri Community-Based Home Visiting, Nurse Family Partnership (Building Blocks of Missouri) Home Visiting, and Alternatives to Abortion programs educate their clients on not smoking during pregnancy.		X	X	
5. Smoking cessation educational cards targeted young moms and dads with information about the dangers of tobacco use and secondhand smoke to unborn babies.			X	
6. Baby Your Baby website (http://www.dhss.mo.gov/babyyourbaby), Baby Your Baby Health Keepsake Books, and educational brochures in English, Spanish, Vietnamese, and Chinese provided information about smoking cessation during pregnancy.			X	
7. TEL-LINK is the MCH toll-free information and referral line and provides referral to the Missouri Tobacco Quit Line for information related to smoking cessation.		X		
8. Alternatives to Abortion providers who provide individual\group prenatal and parenting education, must educate on smoking during pregnancy as one of the mandatory education topics.		X	X	
9. CCHC group education on the risks of smoking and second hand smoke.		X		
10.				

b. Current Activities

Activities listed in Table 4b will be continued.

Twenty three of the 112 Local Public Health Agencies serving 23 counties/cities are focusing on addressing tobacco prevention as their priority health need.

LPHA contractors addressing this issue through MCH Coordinated Systems contracts are expanding staff training in interventions such as Freedom from Smoking and increasing community efforts to establish smoke free campuses, restaurants and community/city wide Clean Air Ordinances. LPHAs continue to provide smoking cessation/prevention education through WIC programs, prenatal case management, other services offered by the health department that include pregnant women, school nurses, and community/statewide campaigns.

As of the end of 2009, at least 18 communities in Missouri have adopted an ordinance restricting smoking in some or all public places in their communities, with 9 communities having comprehensive smoke-free ordinances, covering workplaces, restaurants and bars. Currently, there are 25 active local tobacco control coalitions working on smoke-free policies.

c. Plan for the Coming Year
This State Performance Measure has changed based on the results of the Needs Assessment. The new performance measure will be the percent of women aged 18-44 years who are current cigarette smokers. This performance measure was chosen to better represent the Life Course Perspective and in recognition of the effect of smoking preconceptually.

While the plan for the coming year is still being developed, some activities already identified for this measure are listed below.

Clients who receive a crib through the Safe Cribs for Missouri program and who have smoking in their home will be educated on the dangers of secondhand smoke during the two educational sessions that are part of the cribs program.

Many women working in child care facilities are of reproductive age. The Child Care Health Consultation program offers staff education on the hazards of smoking and second hand-smoke. Referral to appropriate smoking cessation programs will be available upon request.

Office of Women's Health will collaborate with Adolescent Health and outside stakeholders on the Preconception Health for Adolescents initiative to address the negative effects of tobacco on women through education and training activities.

State Performance Measure 2: *Percent of cigarette smoking among children 14-18 years of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	30	19.4	17.4	23.3	22.8
Annual Indicator	21.3	21.3	23.8	23.8	18.9
Numerator	59081	60210	68127	67789	53275
Denominator	277374	282678	286247	284830	281879
Data Source				Missouri Youth Risk Behavioral Survey	Missouri Youth Risk Behavioral Survey
Is the Data Provisional or Final?				Provisional	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	22.3	21.8	21.3	20.8	

Notes - 2009
Source: Annual indicator is percentage from 2009 CDC's Youth Risk Behavioral Survey "Percentage of high school students who smoked cigarettes on one or more of the past 30 days. Numerator is based on percentage. Denominator is estimate using number of fall enrollment grades 9-12 for school year 2008-2009 obtained from the MO Dept. of Elementary & Secondary Education.

An annual decrease of 0.2% was chosen for objectives 2010-2014, based on trend data 1995-2009 and discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2008
Source: Annual indicator is percentage from 2007 CDC's Youth Risk Behavioral Survey "Percentage of high school students who smoked cigarettes on one or more of the past 30 days.

Numerator is based on percentage. Denominator is estimate using number of fall enrollment grades 9-12 for school year 2007-2008 obtained from the MO Dept. of Elementary & Secondary Education.
YRBS survey is conducted every 2 years. Next survey results will be available summer 2010.

Objectives for 2009-2013 were set with considerations of trend analysis on MO YRBS data 1995-2007, and discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2007
The annual indicator is from the 2007 YRBS statistic "Percentage of high school students who smoked cigarettes on one or more of the past 30 days". The denominator is estimated using the number of fall enrollment, grades 9-12 for school year 2006-2007, obtained from the the MO Department of Elementary and Secondary Education.

Objectives for 2008-2012 were set with considerations of trend analysis on MO YRBS data 1995-2007, and discussions with the Section of Healthy Families and Youth, MO DHSS.

a. Last Year's Accomplishments
MCH Coordinated Systems supported 23 contracts with Local Public Health Agencies (LPHAs) who selected tobacco prevention/cessation as priority health issue to address with schools and other community partners and targeted the adolescent population. Various evidence-based programs have been implemented in collaboration with schools such as Smokebusters, TATU, NOT, Nix the Stix, TAR Wars, and Yea! Team! that involve peer-counseling of older students to younger and advocacy skills for smoke free campuses and communities. MCH program staff provided fall trainings with content experts on tobacco prevention/cessation programs and advocacy for environmental/policy change. Statewide spring training for LPHAs with St. Louis University School of Public Health focused on how to use logic models to develop and evaluate programs.

Various DHSS programs explored ways to integrate tobacco use prevention strategies, including youth development and advocacy, with other adolescent health-related concerns into TOP, contracts with schools, LPHAs, Smoke Busters and Teens Against Tobacco program models to effectively engage youth.

Youth advocacy and prevention groups supported and promoted include Smokebusters and Youth Empowerment in Action Tobacco Education, Advocacy, and Media (YEA TEAM). State funding in 2008-2011 has allowed the program to spread to Kansas City and western Missouri and to more counties in the southwest. State funding from 2007-2011 for the YEA TEAM program has allowed the program to spread to more schools in the St. Louis area. Accomplishments from the school programs include youth advocacy, prevention, and empowering youth to seek environmental and policy change in their communities.

In February 2009, 396 high school youth, 26 college students and 168 adult mentors participated in a statewide Youth Tobacco Summit held in Jefferson City. The event was a great success and featured motivational speakers, advanced training in tobacco control leadership, and interactive educational sessions.

Through the School Health Services contracts: 12 school districts (representing 31,000 children) had the goal to become smoke free, 8 school districts (representing 17,000 children) included Smoke Busters programs, 10 school districts supported smoking cessation programs, and 8 school districts (representing 25,000 children) included tobacco-use prevention in their health education programs.

City ordinances in Kansas City, North Kansas City, Liberty, and Gladstone were passed enforcing restrictions for minors purchasing tobacco products. These clean air ordinances are more stringent than state law. Also, all public schools in Clay County have smoke free campus policies.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Students involved with tobacco prevention programs advocate for smoke free school campuses with local school boards.			X	X
2. High school students participated in statewide Tobacco Summit.		X	X	X
3. MCH District Nurse Consultants provide technical assistance, consultation, and resources to schools and communities on implementing smoke free policies.			X	
4. Health fairs in school setting provided education and visual aids on effects of tobacco use.			X	
5. AHP, CASH, TOP contractors, and DHSS Tobacco Control Program collaboratively promote youth tobacco-free Missouri activities in communities and schools.			X	X
6. Tobacco use prevention and cessation is one of the adolescent preconception health promotion concerns to be addressed.			X	
7. CCHC group education on the risks of second-hand smoke.		X	X	
8.				
9.				
10.				

b. Current Activities
Activities listed in Table 4b will be continued.

LPHAs contracting with MCH Coordinated Services continue to evaluate schools/community for tobacco programs offered and will share this data with community coalition in identifying gaps and planning for future efforts.

Community coalitions will continue to work together to implement Clean Air Ordinances and smoke-free campuses/restaurants and other businesses. LPHAs serve on School Health Advisory Committees and assist with development/promotion of school wellness policies.

c. Plan for the Coming Year
Activities listed in Table 4b will be continued.

Various DHSS programs and CASH will continue to work together on integrating tobacco use prevention strategies, including youth development and advocacy, with other adolescent health-related concerns into TOP, contracts with schools, LPHAs.

The School Health Services program is present in nearly 50% of the public school districts in Missouri. All program managers will be provided age-appropriate information regarding tobacco use prevention. Plans developed by schools will be monitored by the SHS program.

MCH Coordinated Systems LPHA contractors will expand provision of evidence based programs/promising practices implemented within local schools; evaluate those programs; continue to expand community partnerships; and advocate/support smoke free policy changes in schools, worksites, restaurants, and city/county wide.

State Performance Measure 3: *Percent of mothers who are prepregnancy overweight by 20% or more.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		35.2	34.7	36.8	37.4
Annual Indicator	36.5	36.7	36.9	37.5	38.2
Numerator	28637	29832	30220	30334	30037
Denominator	78547	81353	81883	80944	78631
Data Source				MO DHSS. Vital Statistics	MO DHSS. Vital Statistics
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	37.3	37.2	37.1	37	

Notes - 2009
Source: Missouri Information for Community Assessment (MICA)-Births, DHSS Vital Statistics. Provisional 2009 live births number as of April, 2010. Final data will be available, November, 2010.

Notes - 2008
Source: Missouri Information for Community Assessment (MICA)-Births. DHSS Vital Statistics. Provisional 2008 live births number as of April, 2009. Final data will be available, November, 2009.

The steady increasing trend in prepregnancy overweight in MO mirrors the secular trend in overweight and obesity among general women population in both MO and the U.S. Reducing obesity is a priority of the state. We intend to make every effort to make progress in this measure. An annual decrease of 0.1% was set to create objectives 2009-2013.

Notes - 2007
Source: Missouri Information for Community Assessment (MICA) - Birth
and Bureau of Health Informatics, MO DHSS. 2007provisional data as of April 28, 2008. 2007 final birth data will be available in October 2008.

The trend analysis on data 1990-2007 shows the increasing trend in prepregnancy overweight in Missouri has tended to slowdown since 2004 but not yet revsersed. A slight decrease from the current level would be an improvement. An annual decrease of 0.1% was set to create future objectives 2008-2012.

a. Last Year's Accomplishments
MCH Coordinated Systems multi-year contracts with 48 LPHAs to address obesity prevention as the priority health issue requires systems development with community partners and evidence based interventions. Fall regional trainings offered round table discussions with content experts from the DHSS chronic disease program and MO University Extension on best practices. LPHAs have used Title V funds to leverage additional funding for more comprehensive system approach. LPHAs have developed/advertised websites promoting healthy eating and physical activity, which include maps for walking trails and healthy recipes.

Missouri Convergence Partnership is made up of organizations that provide funds to communities. This Partnership was convened January 9, 2008, by the Missouri Foundation for

Health and the University of Missouri Columbia Foundation Relations Office. The Partnership was modeled on the national Healthy Eating/Active Living Convergence Partnership. Missouri did use this Partnership as a vehicle to work together across sectors to advance healthy lifestyles and reduce the obesity burden.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. LPHAs/community collaboratives have developed/promoted community gardens at schools, low income housing, rural and urban locations.			X	
2. LPHAs promoted health eating choices and physical activity through WIC, prenatal case management with follow up to post partum mothers, home visits to newborns and through other services such as family planning programs.		X	X	
3. Community collaboratives developed and promoted safe walking trails, sidewalks, and weight loss challenges within communities, worksites and faith-based organizations.			X	X
4. Worksite wellness programs, farmer's markets and collaboration with YMCAs for reduced membership.			X	X
5. School policy changes to provide healthy choices in vending machines and cafeterias.			X	
6. Chronic Disease and Primary Prevention Program funds community wide initiatives that encourage policy and environmental changes to increase access to healthy food and physical activity.			X	
7. The Missouri Community-Based Home Visiting, Nurse Family Partnership (Building Blocks of Missouri) Home Visiting programs collect data on their client's pre-pregnancy weight and educate them on proper nutrition and weight gain during pregnancy.		X	X	
8.				
9.				
10.				

b. Current Activities

Activities listed in Table 4b will be continued.

The St. Louis City LPHA promoted community gardens and physical activity efforts during National Public Health Week., including utilizing elementary student showing parents how to cook healthier using fresh produce. LPHAs are developing Facebook accounts to promote healthy messages and programs. LPHAs are evaluating systems for addressing obesity.

In May 2010, the Bureau of Genetics and Healthy Childhood in cooperation with the Bureau of Health Informatics will re-implement the Pregnancy Associated Mortality Review program for the years 2004-2008. The program will look at the causes of death for women who died while they were pregnant of within one year of the termination of their pregnancy including obesity and other diagnosis brought on by overweight and obesity.

Forty-eight of the 112 Local Public Health Agencies serving 52 counties/cities are focusing on addressing obesity prevention as their priority health need.

Chronic Disease and Primary Prevention Program currently supports 23 counties and 1 city.

Community projects include starting farmers' markets and community gardens, building trails, using schools for community activity, and other educational programs to encourage good nutrition habits.

c. Plan for the Coming Year
Activities listed in Table 4b will be continued.

A priority health issue to be addressed by the CCHC program in FFY 2011 is obesity prevention in child care. Education regarding nutrition and physical activity for children will also be applied to staff health. Many women working in child care facilities are of reproductive age and thus this staff education has significance related to reproductive health.

MCH Coordinated Systems LPHA contractors and partners will be implementing and evaluating environmental changes such as complete streets, campaigns such as community/worksite weight loss challenges; expansion of community gardens and education on preparing healthy meals. Increasing faith based partnerships and nutrition policy changes within schools. One rural LPHAs grassroots efforts led to recently pass a recreational tax to help pay for two parks with walking trails.

Office of Women's Health (OWH) will collaborate with Adolescent Health and outside stakeholders on the Preconception Health for Adolescents initiative to address the negative effects of overweight/obesity on women through education and training activities.

Bureau of Health Informatics (BHI) will redesign the Birth MICA to include a BMI indicator instead of the currently-used Weight-for-Height indicator based on the Metropolitan Life Insurance Tables.

State Performance Measure 4: *Percent of high school students who met currently recommended levels of physical activity.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		71.2	72.8	44.5	45.5
Annual Indicator	36.0	36.0	43.5	43.5	48.3
Numerator	99854	101764	124517	123901	136148
Denominator	277374	282678	286247	284830	281879
Data Source				Missouri Youth Risk Behavioral Survey	Missouri Youth Risk Behavioral Survey
Is the Data Provisional or Final?				Provisional	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	46.5	47.5	48.5	49.5	

Notes - 2009
Source: Youth Risk Behavioral Survey (YRBS) 2009
A response of 5 or more days to the survey item "During the past 7 days, on how many days were you physically active for a total of at least 60 minutes per day?" (Add up all the time you spend on any kind of physical activity that increases your heart rate and makes you breathe hard part of the time). Denominator is the number of enrollment of grades 9-12 during the 2008-2009

school year, obtained from the Mo Dept of Elementary and Secondary Education.

An annual increase of 1% was chosen for objectives 2010-2014, based on data 2005-2009 and discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2008
Source: Youth Risk Behavioral Survey (YRBS) 2007
A response of 5 or more days to the survey item "During the past 7 days, on how many days were you physically active for a total of at least 60 minutes per day?" (Add up all the time you spend on any kind of physical activity that increases your heart rate and makes you breathe hard part of the time). The 2007 YRBS estimate is being used as a proxy for 2008 obtained from the Mo Dept of Elementary and Secondary Education. Denominator is the number of enrollment of grades 9-12 during the 2007-2008 school year.
YRBS survey is conducted every 2 years. Next survey results will be available summer 2010.

An annual increase of 1% on this measure was chosen to create objectives for 2009-2013, based on estimates of the indicator in 2005 and 2007, comparisons with other states, and discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2007
The question used to estimate the indicator SPM # 4 "percent of students who participated in vigorous physical activity" was discontinued in the 2007 YRBS questionnaire: "On how many of the past 7 days did you exercise or participate in physical activity for at least 20 minutes that made you sweat and breathe hard ?". Instead, to reflect the current physical activity recommendation for youth, defined as "participation in any kind of physical activity that increased their heart rate and made them breathe hard some of the time for a total of at least 60 minutes/day on >=5 of the 7 days preceding the survey", a new question has been added to YRBS since the 2005 survey: "During the past 7 days, on how many days were you physically active for a total of at least 60 minutes per day? (Add up all the time you spend in any kind of physical activity that increases your heart rate and makes you breathe hard some of the time.)"

2007 YRBS estimate was obtained from the Missouri Department of Elementary and Secondary Education. The 2007 data was based on the new indicator "percent of students who were physically active for a total of at least 60 minutes per day on >=5 of the past 7 days". The data reported for 2007 is comparable with the data for 2005 but not comparable with data before 2005, which reflect previously recommended physical activity for youth. Denominator is number of fall enrollment of grades 9-12 during school year 2006-2007 from the Missouri Department of Elementary and Secondary Education.

YRBS data for the new indicator were only available for two years 2005 and 2007, which prevented the ability to conduct trend analyses. An annual increase of 1% on the new indicator was chosen to create future objectives for 2008-2012, based on estimates of the new indicator in 2005 and 2007, comparisons with other states, and discussions with the Section of Healthy Families and Youth, MO DHSS.

a. Last Year's Accomplishments
MCH Coordinated System multi-year contracts with 48 LPHAs addressing obesity prevention required a systems approach and implementation of evidence-based interventions determined by community collaborative. MCH staff participate in Missouri Council on Activity and Nutrition (MoCAN) to develop statewide efforts and environmental/policy change around obesity.

Adolescent Health Program (AHP) disseminated copies of the Child and Adolescent Healthcare Provider Tool Kit for promoting nutrition and physical activity at regional adolescent health trainings.

The School Health Services Program had a performance measure based upon the CDC, School

Health Index, with 645 interventions related to increased physical activity. Some examples of interventions were:
-partnering with the Missouri Extension Service to develop and distribute a DVD titled "Moving and Grooving". This DVD led students and staff in physical activities that can be done in the classroom. Nearly half of schools in the School Health Services Program report using this DVD. A second DVD was developed at the requests of the schools focusing on Yoga and relaxation techniques.
-School Nurses and School Health Advisory Councils sponsored "Walking School Bus" programs, walks before school and at recess, as well as formal walking programs.
-School nurses partnered with physical education staff to sponsor "open gyms" in the morning before school for use by students.

The DHSS participates in the Safe Routes to School State Network. Safe Routes to School provides funding for schools to create safe places for children to walk to school and to conduct educational campaigns to increase support for safe routes and walking to school.

The Extreme Health Challenge project focuses on providing classroom nutrition education and physical activity to fourth and fifth grade students. Parents are brought into the program through the PTA.

The DHSS participates on an interdepartmental committee "Children in Nature Challenge" that is working to encouraging communities to get children into nature. There is a website and a recognition program being developed.

The Hickory County LPHA collaborated with a local school and the Corps of Engineers to develop a walking/running/biking trail on recreational lake to provide a safe place for students on cross country track team. The trail is also promoted to and used by community residents and visitors.

School Health Services worked with 231 public schools to make changes in policies and practices related to physical activity and nutrition. Examples of policy changes which occurred were:
-including healthy snacks in the vending machines (eliminating soda, high sugar and salty snacks) and changing the hours of availability of vending machines;
-changing to "Recess Before Lunch";
-one monthly birthday party rather than birthday parties for individual children;
-sending home an approved list of healthy foods for parties, and
-increased availability of school breakfast program for all children.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. LPHAs worked with schools and other partners to provide health fairs and walk/runs to increase awareness of importance of physical activity.			X	
2. Professional Development offered for schools related to physical activity and nutrition practices at regional meetings.			X	
3. AHP provide Child and Adolescent Healthcare Providers Tool Kits at regional trainings.			X	
4. CASH and Adolescent Preconception Health Team address physical activity/healthy eating through various educational strategies.			X	
5. School Health Services program continues to utilize the School Health Index to measure physical activity.			X	
6. LPHAs will continue participation on School Health Advisory Committees.				X

7.				
8.				
9.				
10.				

b. Current Activities
Activities listed in Table 4b will be continued.

LPHAs are developing Facebook pages to promote physical activity and healthy eating to adolescents. LPHAs are beginning to evaluate interventions and their systems approach to this issue. MCH Coordinated Systems with Chronic Disease Prevention, University Extension and Missouri Foundation for Health co-sponsored Building Capacity for Healthy Communities conference.

The School Health Services program continues to support partnerships with programs such as Action for Healthy Kids, the Alliance for a Healthier Generation and the University Extension System and Farm to School Initiatives in an effort to increase physical activity and good nutrition.

c. Plan for the Coming Year
Activities listed in Table 4b will be continued.

New information will be linked to the DHSS Adolescent Health webpage.

Contractors in the School Health Services program have strategies to address increased physical activity. The plans are developed with measureable goals and will be measured at the end of the year.

MCH Coordinated Systems LPHA contractors addressing obesity prevention will increased collaboration with schools and provide data such as impact of physical activity on improved academic performance. Program staff will continue state wide collaboration through MoCAN and CASH to impact policy change for schools at the state level.

State Performance Measure 5: *Percent of women who enrolled in WIC during first trimester of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		51.9	52.1	42.3	41.6
Annual Indicator	42.0	41.6	40.2	43.0	43.0
Numerator	19101	18502	18873	17642	17642
Denominator	45478	44477	46948	41028	41028
Data Source				Missouri Pregnancy Nutrition Surveillance System	Missouri Pregnancy Nutrition Surveillance System
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	41.8	42	42.2	42.4	

Notes - 2009
Source: CDC. Data Tables of the Missouri Pregnancy Nutrition Surveillance System (PNSS). The 2009 numbers will be available in November 2010, 2008 numbers are used as proxy for 2009. 2008 numbers are updated with 2008 data.

Notes - 2008
Source: CDC. Data Tables of the Missouri Pregnancy Nutrition Surveillance System (PNSS). The 2008 numbers will be available in November 2009, 2007 numbers are used as proxy for 2008.

This measure was selected as it reflects the ability of women to identify and access needed services such as applying for Medicaid, food stamps, TANF and accessing prenatal care.

Missouri had the fifth highest percent WIC enrollment during the first trimester among 28 states participating in PNSS in 2007. In FFY 2008, MO WIC began providing additional funds to local WIC providers to increase WIC enrollment among pregnant women. Objectives 2009-2013 were based on a combination of trend analysis on data 1998-2007 and discussions with the WIC Program.

Notes - 2007
Source: CDC. Data Tables of the Missouri Pregnancy Nutrition Surveillance System (PNSS). 2007 numbers will be available in November 2008. 2006 numbers are used as proxy for 2007.

Missouri had the third highest percent of women enrolled in WIC during first trimester of pregnancy among 29 states/territories participating in the PNSS in 2006. Objectives for 2008-2012 were based on trend analysis using the CDC data table of Missouri PNSS 1997-2006, and discussions with the Section of Healthy Families and Youth, MO DHSS.

Data source was changed from Birth certificate records in MICA and WIC Prenatal MICA to Data Tables of the Missouri Pregnancy Nutrition Surveillance System (PNSS) reported by CDC. The change aimed to 1) use the same data source for both numerator and denominator, 2) define the denominator as the number of women enrolled in WIC in either period during pregnancy or postpartum period instead of only the number enrolled in WIC during pregnancy, and 3) make the indicator comparable with other states/territories with PNSS.

The measures in 2006 and 2005 were also revised based on data from the changed data source. Therefore, 2005 and 2006 numbers are not comparable with numbers reported in 2004 and earlier.

a. Last Year's Accomplishments
The Missouri Community-Based Home Visiting referred 815 families, Nurse Family Partnership (Building Blocks of Missouri) Home Visiting programs referred 446 families and Alternatives to Abortion program referred 72 women to WIC.

In FFY 2009, TEL-LINK made 2,255 referrals to WIC.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Missouri Community-Based Home Visiting and Nurse Family Partnership (Building Blocks of Missouri) Home Visiting programs programs refer all women who enroll in their programs to WIC.		X	X	
2. Alternatives to Abortion providers are encouraged to refer all their clients to WIC.		X	X	
3. The TEL-LINK program refers Missourians to the WIC		X	X	

program when requested. Posters, which were developed by the WIC Program, are posted at local health agencies and include the TEL-LINK number.				
4. WIC brochures will to be distributed at various conferences and health fairs that are exhibited.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Activities listed in Table 4b will be continued.

c. Plan for the Coming Year
State Performance Measure has changed based on the results of the Needs Assessment.

State Performance Measure 6: *The incidence of emergency room visits for diseases of teeth and jaw for children ages under 15 per 1,000 population.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		0.9	0.9	0.9	1.7
Annual Indicator	1.0	2.0	2.0	2.1	2.1
Numerator	1126	2389	2286	2512	2512
Denominator	1162408	1169209	1169041	1170036	1170036
Data Source				MO DHSS. Patient Abstract System	MO DHSS. Patient Abstract System
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	1.6	1.5	1.4	1.3	

Notes - 2009
Source: Missouri Information for Community Assessment (MICA)-Emergency Room, MICA-Population. 2009 data are not available yet, 2008 data are used as proxy for 2009. Final 2009 data will be available in November, 2010.
2007 and 2008 numbers are updated with final 2007 and 2008 data.

Numerator is the number of ER visits due to disorders of teeth and jaw.

Notes - 2008
Source: Missouri Information for Community Assessment (MICA)-Emergency Room, MICA-Population. 2008 data are not available yet, 2007 provisional data are used as proxy for 2008. Final 2008 data will be available in November, 2009.

Numerator is the number of ER visits due to disorders of teeth and jaw. In previous reports, numerator for 2006 and earlier used the category-diseases of the mouth excluding dental. In this report, numerators for 2006 and later have been updated using the more related category - disorders of teeth and jaw. The number/rates of ER visits using the category - disorders of teeth and jaw for 2004 and 2005 should be 2,655/2.3 per 1,000 in and 2,468/2.1 per 1,000 respectively.

Objectives 2009-2013 were created based on trend analysis on data 2004-2007, and discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2007
Source: Source: Missouri Information for Community Assessment (MICA) - Emergency Room, and the Bureau of Health Informatics, MO DHSS. 2007 data will be available in December 2008, and 2006 data is used as proxy for 2007.

Objectives 2008-2012 were created based on trend analysis on data 1994-2006, and discussions with the Section of Healthy Families and Youth, MO DHSS.

a. Last Year's Accomplishments
The Oral Health Program reviewed 2005 -2006 Preventive Services Program (PSP) data and 2007 emergency room data. Of the 10 counties with the highest rate of ER visits, all but 1 of the counties participated in the PSP. However, participation rates in these counties were low. For instance 2 counties had fewer than 15 children that were screened and received a fluoride varnish application.

The Child Care Health Consultant (CCHC) program provided 90 hours of consultation or group training to child care providers and parents of young children in child care on the importance of oral health in young children. The program also provided 434 health promotion programs for children in child care on oral health.

The School Health Program has a performance measure regarding oral health promotion/protection. Schools may choose to implement an oral health promotion program or partner with community providers to offer a topical fluoride (rinse or varnish) program. 25,336 students participated in the oral health promotion program and 23,987 in the topical fluoride (rinse or varnish) program.

In School year 2009-2010 the Oral Health Program implemented the Preventive Services Program (PSP) within all state schools for the severely disabled. A total of 474 students ranging from kindergarten to 12th grade were served.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CCHCs provided consultation/education to child care providers regarding the importance of dental health in young children and health promotion programs on oral health to young children.		X	X	
2. Oral Health Promotion Programs offered in schools.			X	
3. Topical Fluoride (rinse or varnish) programs offered at school. Beginning with the 10-11 school year only varnish will be available.			X	
4. Missouri Child Care Resource and Referral Network (MOCCRRN) provided information on dental care to families. Inclusion Specialists provide training and technical assistance on dental care for infants through school age child care providers.			X	

5. The School Health Program has a performance measure related to oral health promotion and prevention featuring an educational program and /or a topical fluoride application.	X		X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Activities listed in Table 4b will be continued.

The Oral Health Program is awaiting 2008 data to compare trends. The counties with the 10 highest rates of ER visits for diseases of the tooth and jaw pain will be prioritized to receive PSP services.

c. Plan for the Coming Year
State Performance Measure has changed based on the results of the Needs Assessment.

State Performance Measure 7: *The incidence of domestic violence per 100,000 population.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		666.4	661.4	660.9	573
Annual Indicator	672.3	685.5	633.5	578.2	617.0
Numerator	38998	40053	37239	34178	36943
Denominator	5800310	5842713	5878415	5911605	5987580
Data Source				Missouri Highway Patrol	Missouri Highway Patrol
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	568	563	558	553	

Notes - 2009
Source: Numerator is number of domestic violence incidents obtained from the 2009 report of the Uniform Crime Reporting Program (UCR), Missouri Highway Patrol. Denominator is 2009 population estimate from the US Census Bureau.

Notes - 2008
Source: Numerator is number of domestic violence incidents obtained from the 2008 report of the Uniform Crime Reporting Program (UCR), Missouri Highway Patrol. Denominator is 2008 population estimate from the US Census Bureau.

Objectives 2009-2013 were based on past performance data 2004-2008, and discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2007
Numerator is number of domestic violence incidents obtained from the 2007 report of the Uniform Crime Reporting Program (UCR) , Missouri State Highway Patrol. Denominator is the population estimate for 2007, obtained from the U.S. Census Bureau.

Objectives 2008-2012 were based on trend analysis on data 2001-2007, and discussions with the Section of Healthy Families and Youth, MO DHSS.

a. Last Year's Accomplishments
MCH Coordinated Systems contracts with 41 LPHAs to address intentional and unintentional injury prevention with community partners by implementing evidence-based interventions. MCH program manager participated on state steering committee to address intimate partner violence through a RWJF grant. A brief screening tool was developed, resources for referral determined in each community and Domestic Violence 101 training to five pilot community groups including the LPHAs, college campuses, one Air Force Base, MO Coalitions Against Domestic and Sexual Violence (MCADSV), law enforcement and others. Policy changes incorporating screening of all women presenting for services at several of the LPHAs and through college health services. Several LPHAs are addressing child abuse and neglect through home visits to newborns, prenatal case management, and partnering with Missouri KIDSFirst, and Children's Trust Fund on increasing community awareness/education. Fall trainings for contractors included round table discussions with content experts from Missouri KIDSFirst and Children's Trust Fund on best practices related to child abuse and neglect.

Twenty-four percent of the women screened in the Missouri Community-Based Home Visiting Program reported a history of being abused by a partner. Those screened positive are referred to a shelter or other location for services and if they refuse the referral, the case manager works with them to develop an emergency plan. While 41% of women enrolled in the Building Blocks Program reported a decrease in physical abuse by their partner from intake to 36 weeks gestation. The Home Visiting Programs use the assessment tool developed by the National Nursing Consortium on Domestic Violence.

The Child Care Health Consultant (CCHC) program provided 39 hours of adult education on child abuse and neglect and 39 programs for young children on recognizing and responding to potential abuse situations.

TOP contractors addressed bullying prevention as a precursor to domestic violence. Abstinence education contractors presented sessions on dealing with pressures and unhealthy relationships.

Nineteen Sexual Assault Prevention (SAP) and 23 Sexual Assault Victim Services (SAV) grantees have contracts to implement activities to prevent violence against women. Conferences, trainings, and technical assistance enhanced the capacity of service providers to develop safe and effective prevention, screening, interventions, and monitoring strategies for sexual assault.

The Sexual Assault Forensic Examination (SAFE) program paid appropriate medical providers for the collection of evidence for cases of alleged sexual assault.

Office of Women's Health (OWH) collaborated with many colleges/universities, jr. high/high schools, other state departments and organizations for the rape education & awareness initiative, Denim Day, to educate, promote and empower individuals to Step Forward - Take a Stand Against Rape. The number of events soared from 80 in 2008 to 268 in 2009. A Social Marketing Campaign was developed to include a Facebook and MySpace presence and a website www.supportdenimday.com. Twitter was also utilized for this campaign. OWH Women's Health Network was utilized to assist in the dissemination and promotion of the campaign. Multiple media opportunities to include radio, television and news print.

In June 2009, the Sexual Assault Prevention & Education and Victims' Services Programs transferred from the Bureau of Genetics and Healthy Childhood to the Office on Women's Health. These programs provide victims of rape or sexual assault advocacy and community counseling support and provide statewide, focused community-based primary sexual assault prevention education to the citizens of Missouri.

Office of Women's Health (OWH) manages the Rape Prevention and Education grant through CDC. This grant provides funding for primary prevention initiatives throughout the state. OWH collaborates with the state coalition and many other stakeholders to develop a statewide primary prevention strategic plan to address sexual violence. The program also contracts with agencies statewide to provide technical assistance and education for primary prevention of sexual violence.

Cass County LPHA partnered with Assistant Prosecuting Attorney and other partners in addressing child abuse and neglect and provided training to community on mandated reporting.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. LPHAs screened clients and referred to local MO Coalitions Against Domestic & Sexual Violence for client follow up and education.			X	
2. LPHAs collaborated with Family Support Workers, Parents as Teachers, local shelters, physicians, Head Start and WIC for screening and providing home visits to high risk families. Environmental assessments and support system for family identified.			X	
3. The Missouri Community-Based Home Visiting and Nurse Family Partnership (Building Blocks of Missouri) Home Visiting programs screen all women who enroll in their programs for domestic violence.	X	X		
4. Home Visiting programs participated in research project with UM-Sinclair School of Nursing and Johns Hopkins University to assess women enrolled in Home Visiting for domestic violence and enrolled in a research-based DOVE intervention.			X	X
5. Sexual Assault Prevention and Sexual Assault Victim Services providers fostered community partnerships and collaboration on evidence-based interventions to prevent violence against women.			X	X
6. Missouri Child Care Resource and Referral Network (MOCCRRN) provided training to child care providers on recognizing and reporting child abuse and neglect.			X	
7. OWH collaborates with many colleges/universities, jr. high/high schools, other state departments and organizations for Denim Day to increase awareness and education of the myths that surround rape and sexual assault.			X	
8. CCHC group education for adults and health promotion programs for young children on recognizing and responding to child abuse and neglect.			X	
9. MOCCRRN trains child care providers on Recognizing and Reporting Child Abuse and Neglect, Shaken Baby Syndrome, Supportive Responses to Troubled Parent-Child Interactions.			X	
10. OWH manages a PHHS grant to provide sexual assault victim services throughout the state. The services provided are group counseling, individual counseling, and advocacy services		X		

for victims of sexual assault.				

b. Current Activities
Activities listed in Table 4b will be continued.

OWH has 13 Sexual Assault Prevention and 23 Sexual Assault Victim Services grantees with contracts to implement activities to prevent violence against women. OWH partners with Missouri Coalition Against Sexual and Domestic Violence to convene a statewide planning committee to develop a statewide plan to prevent sexual violence. A draft plan is expected August 1, 2010. OWH co-sponsored two statewide training events for primary prevention of sexual violence. Planning a four-state conference on primary prevention of sexual violence is in the development stage. Regional trainings are planned throughout the state during spring and summer 2010. A website will be developed by the end of October 2010.

LPHAs are evaluating efforts to address intentional injury prevention with plans to expand on those efforts.

For the first time in 2010 Alternatives to Abortion providers screen all women who enroll in their programs for domestic violence using the assessment tool developed by the National Nursing Consortium on Domestic Violence.

Genetics and Healthy Childhood Chief and State Adolescent Health Coordinator serve on the Sexual Violence Prevention Planning Committee to develop a state plan for primary prevention of sexual violence. This is one of the priorities to be addressed in the Preconception Health for Adolescents initiative.

c. Plan for the Coming Year
State Performance Measure has changed based on the results of the Needs Assessment.

State Performance Measure 8: *Percent of women 18-44 years of age who reported frequent mental distress (FDM) for fourteen or more days during the past thirty days their mental health was not good.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		13	12.8	12.5	15
Annual Indicator	13.0	15.4	12.5	15.4	16.4
Numerator	284935	165284	133682	163490	174107
Denominator	2185654	1073275	1066415	1061625	1061625
Data Source				MO Behavioral Risk Factor Surveillance System	MO Behavioral Risk Factor Surveillance System
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance	14	13	12	11	

Objective					

Notes - 2009
Source: "Percent of women 18-44 years of age reporting their mental health was not good =>14 days in the past thirty days" was obtained from the 2009 Behavioral Risk Factor Surveillance System Survey (BRFSS), Denominator is estimated from the 2008 population of women 18-44 years of age from Missouri Information for Community Assessment (MICA) population. The 2009 population number will be available November, 2010. Numerator is based on BRFSS percentage.

Notes - 2008
Source: "Percent of women 18-44 years of age reporting their mental health was not good =>14 days in the past thirty days" was obtained from the 2008 Behavioral Risk Factor Surveillance System Survey (BRFSS), Denominator is estimated from the 2007 population of women 18-44 years of age from Missouri Information for Community Assessment (MICA) population. The 2008 population number will be available November, 2009. Numerator is based on BRFSS percentage.

This measure was selected as it reflects the mental health of all women of reproductive age, not merely those in the perinatal period. The results of this measure are applicable to all women in the pre-conception stage and reflect implications for care.

The increase in the percentage from 2007 to 2008 was not statistically significant. Objectives 2009-2013 were based on measures in past years and discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2007
Percent of women 18-44 years of age reporting their mental health not good>=14 days in the past 30 days was obtained from the 2007 BRFSS. Denominator was determined using population estimate of women 18-44 years of age for 2006, obtained from the Missouri Information for Community Assessment (MICA) - Population. 2007 population estimate for specific age groups will be available in November 2008.

A decrease of 0.1% every two years was set to create objectives 2008-2012, based on measures in past years and discussions with the Section of Healthy Families and Youth, MO DHSS.

a. Last Year's Accomplishments
In FFY 2009, 17% of the 147 women screened by the Missouri Community-Based Home Visiting program screened positive for depression. Of the 67 women screened by the Building Blocks Program 40% screened positive. Fifty-three percent of women reported feelings of depression on enrollment in the Alternative to Abortions Program. Those who screen positive are referred to their healthcare provider.

The CCHC program provided 20 hours of group education on mental health/stress reduction for child care providers.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Missouri Community-Based Home Visiting and Nurse Family Partnership (Building Blocks of Missouri) Home Visiting programs screened all women for depression. Those who screen positive are referred to their healthcare provider.	X	X		
2. Post Partum Depression (PPD) website and educational brochures educate women, families, and physicians about post			X	X

partum depression.				
3. Post partum depression cards provide links to the website and are available for use in healthcare offices.			X	X
4. An online educational program is available to providers free of charge to teach them how to take care of patients with post partum depression.			X	X
5. The CCHC program provided education for child care providers on mental health/stress reduction.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Activities listed in Table 4a will be continued.

For the first time in 2010 the Alternatives to Abortion programs are required to screen all women at six weeks post partum and other times as indicated for post partum depression using the Edinburgh Post Partum Depression screening tool. Those who screen positive are referred to their healthcare provider.

c. Plan for the Coming Year
This State Performance Measure has changed based on the results of the Needs Assessment.

State Performance Measure 9: *Percent of special needs children ages 3-5 enrolled in public preschool programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		5.9	6.2	5	4.7
Annual Indicator	4.8	4.8	4.9	4.8	4.9
Numerator	10887	10873	11315	11045	11358
Denominator	226072	228356	232099	231892	231892
Data Source				MO Dept. of Elementary & Secondary Education	MO Dept. of Elementary & Secondary Education
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	4.8	4.8	4.9	4.9	

Notes - 2009
Source: Numerator from the Missouri Dept of Elementary & Secondary Education, Division of Special Education. Students with Disabilities Child count provisional 2009. Denominator is population 2008 estimate from CDC WONDER - Population, as proxy for 2009. Final numbers will be available November 2010.

2008 numbers are updated with 2008 final data.

Notes - 2008
Source: Numerator from the Missouri Dept of Elementary & Secondary Education, Division of Special Education. Students with Disabilities Child count provisional 2008. Denominator is population 2007 estimate from U.S. Census used as proxy for 2008. Final numbers will be available November 2009.

An increase of 0.1% every two years were set to create objectives 2009-2013, based on trend analysis on data 2002-2008 and discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2007
Source of numerator: Missouri Department of Elementary and Secondary Education, Division of Special Education. Students with Disabilities Child Count as of December 1, 2007.

Denominator of the population estimate for children ages 3-5 in 2007 will be available in November 2008, and 2006 data is used as proxy for 2007.

Objectives 2008-2012 were based on trend analysis on data 2001-2007 and discussions with the Section of Healthy Families and Youth, MO DHSS.

a. Last Year's Accomplishments
Special Health Care Needs (SHCN) administered the Healthy Children and Youth (HCY) Program and the Children and Youth with Special Health Care Needs (CYSHCNP). Through Service Coordination, both programs assisted CYSHCN in identifying and accessing services and supports, increasing health care options and independence, which may have increased participation in public preschool programs. In FY2009, a total of 3,872 participants/families were served through the HCY and CYSHCNP. Service Coordination Assessments (SCA), Service Plans and Transition Plans were completed with participants/families. SCAs included obtaining information regarding educational needs. SHCN used several transition planning tools. Transition planning was conducted in collaboration with participants and agencies and included preparing for public preschool programs. SHCN linked families with the IDEA Part C (First Steps) Program, Head Start, Parents as Teachers (PAT) and other resources as appropriate.

SHCN partnered with the University of Missouri Columbia Thompson Center who received a grant for Improved Services for Children with Autism Spectrum Disorder and other Developmental Disabilities. In FY2009, First Steps, Parents and Teachers, and Early Childhood Special Education participated in grant activities.

MOCCRRN provided referrals to public preschool programs to families with children with special needs, explaining the types of care available (home, center-based and public preschool), in addition to assisting families in finding vacancies. MOCCRRN also provided technical assistance to public pre-school teachers who care for children with special needs. CCHC Program provided group education to child care providers on the care of CYSHCN.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. SHCN contract for assistive technology.	X	X		X
2. SHCN collaboration with grant activities including Family to Family Health Information Center, Service Integration, and Improved Services for Children with Autism Spectrum Disorder.		X		X
3. The SHCN Healthy Children and Youth Program and		X		X

CYSHCNP provision of Service Coordination, including assessments, service plans, and transition plans.				
4. SHCN collaboration with external agencies.		X		X
5. SHCN facilitation of the Missouri Head Injury Advisory Council and the Traumatic Brain Injury Grant.		X	X	X
6. CCHC group education for child care providers and after school programs on the care of CYSHCN.		X		
7.				
8.				
9.				
10.				

b. Current Activities
Activities listed in Table 4b will be continued.

SHCN facilitates the Missouri Head Injury Advisory Council and the Traumatic Brain Injury Grant. One project of the grant is to facilitate a relationship between Brain Injury Association of MO and UMKC-IHD to allow easy access to peer mentoring services. Another project is to develop a partnership with Head Start with plans to provide staff and parent training on recognition of traumatic brain injury.

MOCCRRN provides referrals to public preschool programs to families with CYSHCN and on-site technical assistance and training to public pre-school teachers who care for CYSHCN. CCHC Program provides group education and individual consultation to child care providers on the care of CYSHCN. These efforts also address the state priority needs of "Supporting Adequate Early Childhood Development and Education in Missouri", "Improving the Mental Health Status of MCH Populations in Missouri" and "Reducing Intentional and Unintentional Injuries Among Infants, Children, and Adolescents in Missouri".

c. Plan for the Coming Year
This State Performance Measure has changed based on the results of the Needs Assessment.

State Performance Measure 10: *Percent of children ages 0-19 years old who received health care at a FQHC.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		7.1	7.5	8.2	8.8
Annual Indicator	6.4	7.2	7.8	8.4	9.2
Numerator	98456	113777	123458	133248	145573
Denominator	1545754	1574087	1583410	1582696	1582696
Data Source				Missouri Primary Care Association	Missouri Primary Care Association
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	9.2	9.6	10	10.4	

Notes - 2009
Source: Numerator is 2009 data from Missouri Primary Care Association. Denominator is 2008 population estimate 0-19 from DHSS Missouri Information for Community Assessment (MICA), as proxy for 2009. 2009 population estimate will be available in November, 2010.

Notes - 2008
Source: Numerator is 2008 data from Missouri Primary Care Association. Denominator is 2007 population estimate 0-19 from US Census used as proxy for 2008. 2008 population estimate will be available in November, 2009.
Objectives 2009-2013 were based on trend analysis on data 2001-2008 and discussions with the Section of Healthy Families and Youth, MO DHSS and Missouri Primary Care Association.

Notes - 2007
Numerator is the number of children 0-19 years of age receiving health care at a FQHC in 2007, obtained from the Missouri Primary Care Association. The denominator of population estimate for children 0-19 for 2007 will be available in November 2008, and 2006 data is used as proxy for 2007.
Objectives 2008-2012 were based on trend analysis on data 2001-2007 and discussions with the Section of Healthy Families and Youth, MO DHSS and Missouri Primary Care Association.

a. Last Year's Accomplishments
Missouri has 21 health centers providing primary care services through more than 140 distinct community based delivery sites, serving over 350,000 individual in 2008. Community Health Centers served residents in 111 of the 115 counties\independent cities in Missouri. Health center sites are located in more than 50 counties with many counties having several satellite centers. Of the patients served by Community Health Centers approximately 38% were age 19 or under.

The Primary Care Resource Initiative for Missouri PRIMO initiatives offers a multi-prong approach to strengthening the development and implementation strategies to define a system of coordinated health care services available and accessible to all Missourians. PRIMO investments made through the Student Loan component are crucial to assure identification, training and retention of Missouri's health care professionals that express an interest to serve in areas of defined need. PRIMO Community Development and Recruitment and Retention components are attentive to the immediate needs of expanding primary medical, dental and mental health care services across the state by providing financial and technical assistance to communities and health professionals to assure access to sustainable affordable quality health care services. The PRIMO program through the investments in FQHCs contributed 54,185 health care encounters to individuals of all age groups for FY2009.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Community Health Centers provide primary care.	X			X
2. The Primary Care Resource Initiative for Missouri PRIMO initiatives.			X	X
3. TEL-LINK, the toll-free information and referral line for maternal and child health services provide referrals for Community Health Centers and distribute brochures to attendees at various health fairs.		X	X	
4.				
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities
Activities listed in Table 4b will be continued.

The number of patient encounters attributed to PRIMO investments for calendar year 2010 will not be available until January 2011.

c. Plan for the Coming Year
Activities listed in Table 4b will be continued.

The school health program will send via e-mail information about FQHC's to school nurses and social workers and host a regional meeting with a representative from the FQHC for school health staff.

The Office of Primary Care and Rural Health (OPCRH) will continue to coordinate with Federally Qualified Health Center (FQHC), Local Public Health Agencies (LPHA), and other community based systems of care to increase access to medical and dental primary care for underserved and vulnerable populations. Efforts include health incentive initiatives such as student and professional loan repayment in return for working in Designated Health Professional Shortage Areas (HPSA), and aiding community efforts to create local systems of healthcare.

MOCCRRN will continue to provide referrals to public preschool programs to families with children with special needs. MOCCRRN will also continue to explain the types of care available (home, center-based and public preschool) to parents, in addition to assisting families in finding openings. MOCCRRN will also continue to provide on-site technical assistance and training to public pre-school teachers who care for children with special needs. These efforts also address the state priority needs of "Supporting Adequate Early Childhood Development and Education in Missouri", "Improving the Mental Health Status of MCH Populations in Missouri" and "Reducing Intentional and Unintentional Injuries Among Infants, Children, and Adolescents in Missouri".

E. Health Status Indicators

Introduction
Bureau of Health Informatics (BHI) is primary source for health data within the state. BHI oversees the statistical support and health care monitoring activities of DHSS; collects, analyzes and distributes health-related information that promotes better understanding of health problems and needs in Missouri; and highlights improvements and progress achieved in the general health status of Missourians.

Data generated by the BHI aid and guide the planning, development and evaluation of programs and services of the department as well as the health-related activities of other agencies, institutions and organizations.

General services of the bureau include: maintaining the needed Vital Statistics infrastructure and data, providing specific statistical publications and preparing, editing and publishing other reports for the department, and disseminating this data via the web and other media.

Surveillance activities include: tracking selected indicators, disseminating data reports, analyzing and interpreting health data, and providing guidance as to how the data products are intended to

be used.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	8.1	8.1	7.9	8.1	8.1
Numerator	6372	6579	6456	6585	6389
Denominator	78549	81353	81883	80944	78631
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Source: Missouri Information for Community Assessment (MICA) - Births,
DHSS Vital Statistics. 2009 provisional data as of April 2010. 2009 final birth data will be available in November 2010.

Numbers for 2008 are updated with 2008 final data.

Notes - 2008
Source: Missouri Information for Community Assessment (MICA) - Births,
DHSS Vital Statistics. 2008 provisional data as of April 2009 Final birth data will be available in October 2009.

Notes - 2007
Source: Missouri Information for Community Assessment (MICA) - Births,
and the Bureau of Health Informatics, MO DHSS. 2007 provisional data as of April 28, 2008. 2007 final birth data will be available in October 2008.

Narrative:
Among the programs and activities which strive to improve the health of pregnant women and access to care and thereby reduce low weight births include: Missouri Community-Based Home Visiting, Nurse Family Partnership (Building Blocks of Missouri) Home Visiting, Alternatives to Abortions, TEL-LINK, Baby Your Baby website (www.dhss.mo.gov/babyyourbaby), Baby Your Baby Health Keepsake Books, Community Health Center, Text4baby. For detailed activities of these interventions refer to National Performance Measure 18.

The Medicaid Managed Care programs in Missouri focus on various Performance Improvement Projects. All managed care programs focus on hi-risk obstetrics care on an on-going basis. Interventions include: 24 hour Nurse Hot Line/Info Line, Perinatal Nurse Telemanagement, Peer to peer educational baby showers, specialty care such as gestational diabetes, 17 P, and Home Care as needed.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	6.3	6.3	6.2	6.4	6.3
Numerator	4761	4938	4890	4985	4783
Denominator	75805	78577	79204	78162	75936
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Source: Missouri Information for Community Assessment (MICA) - Births, DHSS Vital Statistics. 2009 provisional data as of April 2010. 2009 final birth data will be available in November 2010.

Numbers for 2008 are updated with final 2008 data.

Notes - 2008
Source: Missouri Information for Community Assessment (MICA) - Births, DHSS Vital Statistics. 2008 provisional data as of April 2009 Final birth data will be available in October 2009.

Notes - 2007
Source: Missouri Information for Community Assessment (MICA) - Births and the Bureau of Health Informatics, MO DHSS. 2007 provisional data as of April 28, 2008. 2007 final birth data will be available in October 2008.

Narrative:
See Health Status Indicator #01A.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	1.5	1.5	1.5	1.4	1.6
Numerator	1196	1190	1242	1159	1237
Denominator	78549	81353	81883	80944	78631
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Source: Missouri Information for Community Assessment (MICA) - Births,
DHSS Vital Statistics. 2009 provisional data as of April 2010. 2009 final birth data will be available in October 2010.

Numbers for 2008 are updated with 2008 final data.

Notes - 2008
Source: Missouri Information for Community Assessment (MICA) - Births,
DHSS Vital Statistics. 2008 provisional data as of April 2009 Final birth data will be available in October 2009.

Notes - 2007
Source: Missouri Information for Community Assessment (MICA) - Births,
and the Bureau of Health Informatics, MO DHSS. 2007provisional data as of April 28, 2008. 2007 final birth data will be available in October 2008.

Narrative:
See Health Status Indicator #01A.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.1	1.1	1.1	1.1	1.2
Numerator	862	893	903	862	877
Denominator	75805	78577	79204	78162	75936
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Source: Missouri Information for Community Assessment (MICA) - Births,
DHSS Vital Statistics. 2009 provisional data as of April 2010. Final birth data will be available in November,2010.

Numbers for 2008 are updated with 2008 final data.

Notes - 2008
Source: Missouri Information for Community Assessment (MICA) - Births, DHSS Vital Statistics. 2008 provisional data as of April 2009 Final birth data will be available in October 2009.

Notes - 2007
Source: Missouri Information for Community Assessment (MICA) - Births
and the Bureau of Health Informatics, MO DHSS. 2007 provisional data as of April 28, 2008. 2007 final birth data will be available in October 2008.

Narrative:
See Health Status Indicator #01A.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	10.1	10.5	13.3	13.2	12.0
Numerator	114	123	155	155	140
Denominator	1129720	1169209	1169041	1170036	1170036
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Source: Missouri Information for Community Assessment (MICA) - Deaths. DHSS Vital Statistics. Numerator includes motor vehicle accidents & all other unintentional injuries. 2009 provisional data as of April 2010. Final death data will be available in November 2010.
Denominator is population estimate from MICA tables-population.

The 2008 population being used as proxy for 2009. 2009 final population data will be available November 2010.

Numbers for 2008 are updated with 2008 final data.

Notes - 2008
Source: Missouri Information for Community Assessment (MICA) - Deaths. DHSS Vital Statistics. Numerator includes motor vehicle accidents & all other unintentional injuries. 2008 provisional data as of April 2009 Final death data will be available in October 2009. Denominator is population estimate from MICA tables-population. 2007 being used as proxy for 2008. 2008 final population data will be available November 2009.

Notes - 2007
Source: Missouri Information for Community Assessment (MICA) - Deaths, MICA - Population, and Bureau of Health Informatics, MO DHSS. Numerator is based on 2007 provisional death data as of April 28, 2008. Denominator population estimate for children <=14 years of age for 2007 is not available yet, and population estimate for 2006 is used as a proxy for 2007. 2007 final data will be available in November 2008.

Narrative:
The Safe Kids Coalitions implement a variety of prevention and intervention activities as described previously to reduce deaths due to unintentional injuries to children aged 14 years and younger. There were 684 injury prevention events serving over 80,000 children and their parents. Events included bicycle safety, water safety, fire/burn safety, and home safety.

The CCHC program provides consultation and education to child care providers regarding injury prevention in the child care setting. In FFY 2009, 244 hours of education/consultation on injury prevention topics was provided to adults and 578 injury prevention programs to young children.

MCH Services contractors (LPHAs) address a variety of injury prevention activities including bicycle safety, life vests and poisoning.

Refer to National Performance Measure 10 for details of activities related to injury prevention in motor vehicle crashes which are also pertinent to this measure.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	3.7	3.6	3.7	3.1	2.7
Numerator	43	42	43	36	32
Denominator	1162408	1161209	1169041	1170036	1170036
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Source: Missouri Information for Community Assessment (MICA) - Deaths. DHSS Vital Statistics. Numerator includes deaths due to motor vehicle accidents. 2009 provisional data as of April 2010. Final death data will be available in November 2010. Denominator is 2008 population estimate from MICA tables-population. 2008 being used as proxy for 2009. The 2009 final population data will be available November 2010.

Numbers for 2008 are updated with 2008 final data.

Notes - 2008
Source: Missouri Information for Community Assessment (MICA) - Deaths. DHSS Vital Statistics. Numerator includes deaths due to motor vehicle accidents. 2008 provisional data as of April 2009. Final death data will be available in October 2009.

Denominator is population estimate from MICA tables-population. 2007 being used as proxy for 2008. 2008 final data will be available November 2009.

Notes - 2007
Source: Missouri Information for Community Assessment (MICA) - Deaths, MICA - Population, and Bureau of Health Informatics, MO DHSS. Numerator is based on 2007 provisional death data as of April 28, 2008. Denominator population estimate for children <=14 years of age for 2007 is not available yet, and population estimate for 2006 is used as a proxy for 2007. 2007 final data will be available in November 2008.

Narrative:
Numerous activities which include car seat and booster seat fitting stations/distribution/safety and campaigns to increase awareness of booster seat laws, promotion/distribution of life jackets for children 7 and younger at large recreational lake, ATV safety, bicycle safety and helmet use, and seat belt use are conducted throughout the state.

Refer to National Performance Measure 10 for detailed activities related to this measure.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	40.6	36.1	30.7	29.8	23.6
Numerator	335	297	250	242	192
Denominator	824951	823814	813974	811896	811896
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Source: Missouri Information for Community Assessment (MICA) - Deaths. DHSS Vital Statistics. Numerator includes deaths due to motor vehicle accidents. The 2009 provisional data as of April 2010. Final death data will be available in November 2010. Denominator is 2008 population estimate from MICA tables-population. 2009 population data will be available November 2010.

Numbers for 2008 are updated with 2008 final data.

Notes - 2008
Source: Missouri Information for Community Assessment (MICA) - Deaths. DHSS Vital Statistics. Numerator includes deaths due to motor vehicle accidents. 2008 provisional data as of April 2009 Final death data will be available in October 2009. Denominator is population estimate from MICA tables-population. 2007 being used as proxy for 2008. 2008 final data will be available November 2009.

Notes - 2007
Source: Missouri Information for Community Assessment (MICA) - Deaths, MICA - Population, and Bureau of Health Informatics, MO DHSS. Numerator is based on 2007 provisional death data as of April 28, 2008. Denominator population estimate for youth 15-24 years of age for 2007 is not available yet and population estimate for 2006 is used as a proxy for 2007. 2007 final data will be available in November 2008.

Narrative:
The Bureau of Genetics and Healthy Childhood has developed a series of car seat safety cards that are available to educate families on car seat safety. The series includes safety for adolescents.

DHSS contracts with ThinkFirst Missouri to provide education and resource information to middle and high school adolescents regarding head and spinal cord injuries. This program is called ThinkFirst for Teens. While the focus of ThinkFirst is directed towards reducing disabling injuries to the brain and spinal cord, the injury prevention messages conveyed are also effective in reducing the death rate from these injuries. A total of 67 programs were presented in 74 schools to 15,136 middle, junior and high school students regarding spinal cord and brain injuries.

MCH Services contractors are addressing with bicycle safety, life vests and poisoning and by promoting seat best use through Battle of the Belts competition and Arrive Alive campaigns with high school students.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	204.2	197.5	199.9	177.4	177.4
Numerator	2374	2309	2337	2076	2076
Denominator	1162408	1169209	1169041	1170036	1170036
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Source: DHSS. Missouri Information for Community Assessment (MICA) - Injuries, Hospital Patient Abstract System(PAS), & MICA-Population. Numerator is 2008 injury data as a proxy for 2009. Final hospital data are available April 2011. Denominator is 2008 population estimate of children age 14 year & under, as a proxy for 2009. The 2009 population data will be available November 2010.

The numerator is estimated by taking number of inpatient hospitalizations for unintentional injuries minus the number died from the injuries among children aged <=14 years.

Notes - 2008
Source: DHSS. Missouri Information for Community Assessment (MICA) - Injuries, Patient Abstract System, & MICA-Population. Numerator is 2007 provisional injury data as a proxy for 2008. Denominator is population estimate of children age 14 year & under in 2007, as a proxy for 2008. 2008 data will be available November 2009.

The numerator is estimated by taking number of inpatient hospitalizations for unintentional injuries minus the number died from the injuries among children aged <=14 years.

Notes - 2007
Source: Missouri Information for Community Assessment (MICA) - Injury, MICA - Population, and Bureau of Health Informatics, MO DHSS. 2007 data are not available yet and 2006 data are used as proxy for 2007. 2007 final data will be available in December 2008.

The numerator is estimated by taking number of inpatient hospitalizations for unintentional injuries minus the number died from the injuries among children aged <=14 years.

Narrative:
Safe Kids Coalitions provide education, resources, and activities regarding car seat safety, bicycle safety, poisoning, water safety, safe home and school environments.

There were 684 injury prevention events serving over 80,000 children and their parents. Events included bicycle safety, water safety, fire/burn safety, and home safety.

The Child Care Health Consultation Program provides consultation and education to child care providers regarding injury prevention in the child care setting. In FFY 2009, 244 hours of education/consultation on injury prevention topics were provided to adults and 578 injury prevention programs were provided to young children.

MCH Services contractors address bicycle safety, life vests and poisoning.

Forty-one of the 112 Local Public Health Agencies serving 39 counties/cities are focusing on addressing injury prevention as their priority health need.

Collaboration with Special Projects of Regional and National Significance (SPRANS) has occurred and with the Traumatic Brain Injury (TBI) Demonstration Grant Program, which provides grants to States to implement systems that ensure access to comprehensive and coordinated TBI services. One of the target populations in Missouri is children acquiring a TBI between the ages of 0-4. The needs and resources assessment identified limited public knowledge of TBI as being a major barrier to services for the preschool population. The overall goal of the grant is "to provide individuals with traumatic brain injuries and their families with improved access to comprehensive, multidisciplinary, coordinated and easily accessible systems of care." Through this grant, the DHSS Bureau of Special Health Care Needs (SHCN) and Missouri Head Start are in the early stages of a partnership to provide education, training and information dissemination to increase public awareness and enhance service delivery to this underserved population. DHSS will continue to identify systems that provide services to this population and develop partnerships throughout this grant to work towards a comprehensive system of care for this population.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	62.6	55.0	47.2	40.6	40.6
Numerator	728	643	552	475	475
Denominator	1162408	1169209	1169228	1170036	1170036
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009

Source: DHSS. Missouri Information for Community Assessment (MICA) - Injuries, Hospital Patient Abstract System (PAS), & MICA-Population. Numerator is 2008 injury data as a proxy for 2009. Final PAS data will be available on April 2011. Denominator is 2008 population estimate of children age 14 year & under as a proxy for 2009. The 2009 population data will be available November 2010.

The numerator is estimated by taking number of inpatient hospitalizations for unintentional injuries due to motor vehicle traffic and non-traffic crashes minus the number died from the injuries among children aged <=14 years.

Notes - 2008

Source: DHSS. Missouri Information for Community Assessment (MICA) - Injuries, Patient Abstract System, & MICA-Population. Numerator is 2007 provisional injury data as a proxy for 2008. Denominator is population estimate of children age 14 year & under in 2007, as a proxy for 2008. 2008 data will be available November 2009.

The numerator is estimated by taking number of inpatient hospitalizations for unintentional injuries due to motor vehicle traffic and non-traffic crashes minus the number died from the injuries among children aged <=14 years.

Notes - 2007
Source: Missouri Information for Community Assessment (MICA) - Injury, MICA - Population, and the Bureau of Health Informatics, MO DHSS. 2007 data are not available yet, and 2006 data are used as proxy for 2007. 2007 final data will be available in December 2008.

The numerator is estimated by taking number of inpatient hospitalizations for unintentional injuries due to motor vehicle traffic and non-traffic crashes minus the number died from the injuries among children aged <=14 years.

Narrative:
Safe Kids Coalitions provide education and resources for child passenger safety, instruction for proper car seat installation and use, and conduct car seat safety checks for children aged 14 years and younger. A total of 7,565 car seats were checked and/or distributed and child passenger safety information provided at 154 events during the year.

In FFY 2009 the Child Care Health Consultation Program provided 19 hours of education/consultation regarding motor vehicle safety to child care providers.

Missouri Department of Transportation provides car seats to LPHAs participating in SAFE Kids Coalitions and Arrive Alive campaigns with high schools.

MCH Services contractors implementing programs for car/booster seats and seat belt use.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	254.6	252.8	218.9	203.6	203.6
Numerator	2100	2062	1777	1653	1653
Denominator	824951	815536	811739	811896	811896
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Source: DHSS. Missouri Information for Community Assessment (MICA) - Injuries, Hospital Patient Abstract System, & MICA-Population. Numerator is 2008 injury data as a proxy for 2009. Final PAS data will be available April 2011, Denominator is 2008 population estimate of youth aged 15-24 as a proxy for 2009. The 2009 population data will be available November 2010.

The numerator is estimated by taking number of inpatient hospitalizations for unintentional injuries due to motor vehicle traffic and non-traffic crashes minus the number died from the injuries among youth aged 15-24.

Notes - 2008
Source: DHSS. Missouri Information for Community Assessment (MICA) - Injuries, Patient Abstract System, & MICA-Population. Numerator is 2007 provisional injury data as a proxy for 2008. Denominator is population estimate of youth aged 15-24 in 2007, as a proxy for 2008. 2008 data will be available November 2009.

The numerator is estimated by taking number of inpatient hospitalizations for unintentional injuries due to motor vehicle traffic and non-traffic crashes minus the number died from the injuries among youth aged 15-24.

Notes - 2007
Source: Missouri Information for Community Assessment (MICA) - Injury, MICA - Population, and the Bureau of Health Informatics, MO DHSS. 2007 data are not available yet and 2006 data are used as proxy for 2007. 2007 final data will be available in December 2008.

The numerator is estimated by taking number of inpatient hospitalizations for unintentional injuries due to motor vehicle traffic and non-traffic crashes minus the number died from the injuries among youth aged 15-24 years.

Narrative:
DHSS contracted with ThinkFirst Missouri to provide education and resource information to middle and high school students regarding head and spinal cord injuries. ThinkFirst for Teens, provides an assembly program with an informative presentation, compelling testimony from a survivor, high-impact video, and a interactive question and answer session. A total of 67 programs were presented in 74 schools to 15,136 middle, junior and high school students regarding spinal cord and brain injuries.

MCH contractors promoting seat best use through Battle of the Belts competition and Arrive Alive campaigns with high school students.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	34.4	34.3	34.8	37.5	39.3
Numerator	6856	6909	7027	7549	7922
Denominator	199543	201137	201706	201433	201433
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009

Source: DHSS Bureau of HIV, STD, & Hepatitis.
Denominator is 2008 population estimate for women age 15-19 years, obtained from MO DHSS (Missouri Information for Community Assessment) MICA-Population. 2009 population estimate will be available in November 2010. Numerator is from the Epidemiologic Profiles of HIV/AIDS and STDs in Missouri. Numerator is the number of reported cases in women ages 15-19 years in 2009. It is not the number of women with chlamydia diagnosis.

Denominator for 2008 is updated with 2008 population estimate.

Notes - 2008
Source: DHSS Center for Disease Control & Environmental Epi Denominator is 2007 population estimate for women age 15-19 years, obtained from MO DHSS (Missouri Information for Community Assessment) MICA-Population. 2008 population estimate will be available in November 2009. Numerator is from the Epidemiologic Profiles of HIV/AIDS and STDs in Missouri. Numerator is the number of reported cases in women ages 15-19 years in 2008. It is not the number of women with chlamydia diagnosis.

Notes - 2007
Numerator is obtained from the Epidemiologic Profiles of HIV/AIDS and STDs in Missouri; denominator population estimate for women aged 15-19 years in 2007 is not available yet, and the 2006 estimate is used as a proxy for 2007. 2007 population estimate for specific age groups will be available in November 2008.

Narrative:
The Bureau of HIV, STD, and Hepatitis began a social marketing campaign in April 2009 using both MySpace and Facebook social networks. These social network presences are promoted through links on flyers and documents. Over the past year it has become apparent that Facebook is a better means than MySpace in promoting this program's messages. Information on relevant prevention and awareness materials that include videos, links, documents, and discussion topics are posted. Information is also posted regarding events held throughout the state. Two paid Facebook advertising campaigns have been completed. The first campaign during the last two weeks of December 2009 resulted in a 60% increase in fans/likers and a daily 100-200% increase in page views. In April 2010, four different ads were promoted for four weeks. The increase in fans/likers was not as significant as the December campaign. However, page views still represented a 400% increase over the average of the prior three months.

In March 2009, the Bureau of HIV, STDs, and Hepatitis launched its "Take Control, Take the Test" social marketing campaign targeting Missouri adolescent females. The campaign is meant to increase awareness of sexually transmitted diseases, including HIV, and to reduce the stigma associated with getting tested. A website was created (www.takethetest.info) that includes a test site locator and links to the Bureau's Facebook and MySpace pages. Materials promoting the website were created by a public relations firm and used in schools, clubs, and other areas where adolescents congregate.

The State Public Health Lab performs approximately 80,000 gonorrhea and chlamydia tests per year. The majority of this testing is provided through the Missouri Infertility Prevention Project (MIPP) which focuses on the prevention and early treatment of chlamydial and gonococcal infections through the collaborative effort of health care providers throughout Missouri. MIPP screens women 25 years of age and younger for Chlamydia annually. The overarching goal of MIPP is to lead a collaborative effort to prevent and reduce STD-related infertility.

Missouri is part of Region VII along with Kansas, Nebraska and Iowa. Federal funds also support the regional advisory committees and their collaborative work, including the chlamydia prevalence monitoring surveillance system to monitor trends in disease and to evaluate program impact. The program works closely with high prevalence contracted sites to conduct screening, provide

treatment, and conduct partner management. On average the MIPP program has 80 sites that conduct annual screening on women 25 years and younger; symptomatic males or those males who are known sexual contacts to infected patients.

The Adolescent Health Coordinator serves on the MO Infertility Prevention Project (MIPP) Advisory Committee that addresses screening and treatment of STDs. Several DHSS teams are collectively addressing prevention of STDs and teen pregnancy.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	9.3	9.6	9.7	10.3	10.7
Numerator	9256	9542	9625	10126	10494
Denominator	1000208	996798	989565	983458	983458
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Source: DHSS Bureau of HIV, STD, & Hepatitis.
Denominator is 2008 population estimate for women age 20-24 years, obtained from MO DHSS (Missouri Information for Community Assessment) MICA-Population. 2009 population estimate will be available in November 2010. Numerator is from the Epidemiologic Profiles of HIV/AIDS and STDs in Missouri. Numerator is the number of reported cases in women ages 20-24 years in 2009. It is not the number of women with chlamydia diagnosis.

Notes - 2008
Source: DHSS Bureau of HIV, STD, & Hepatitis.
Denominator is 2007 population estimate for women age 20-24 years, obtained from MO DHSS (Missouri Information for Community Assessment) MICA-Population. 2008 population estimate will be available in November 2009. From the Numerator is from the Epidemiologic Profiles of HIV/AIDS and STDs in Missouri. Numerator is the number of reported cases in women ages 20-44 years in 2008. It is not the number of women with chlamydia diagnosis.

Notes - 2007
Numerator is obtained from the Epidemiologic Profiles of HIV/AIDS and STDs in Missouri; denominator population estimate for women aged 20-44 years in 2007 is not available yet, and the 2006 estimate is used as a proxy for 2007. 2007 population estimate for specific age groups will be available in November 2008.

Narrative:
The Missouri Community-Based and Building Blocks Home Visiting programs assess all women enrolled to determine if they have been previously been or currently diagnosed with Chlamydia and if they received treatment. Women enrolled in these programs are educated on sexually transmitted diseases and the effects they have on the current pregnancy and future fertility.

See Health Status Indicators 05A for other related activities which cross age boundaries.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	80944	65076	12512	0	0	0	0	3356
Children 1 through 4	318506	259660	50318	0	0	0	0	8528
Children 5 through 9	381804	315070	56590	0	0	0	0	10144
Children 10 through 14	388782	320822	58824	0	0	0	0	9136
Children 15 through 19	412660	339374	64504	0	0	0	0	8782
Children 20 through 24	399236	334853	55001	0	0	0	0	9382
Children 0 through 24	1981932	1634855	297749	0	0	0	0	49328

Notes - 2011
Source: DHSS Missouri Information for Community Assessment (MICA) Population 2008 estimates.

Source: DHSS Missouri Information for Community Assessment (MICA) Population 2008 estimates.

Source: DHSS Missouri Information for Community Assessment (MICA) Population 2008 estimates.

Source: DHSS Missouri Information for Community Assessment (MICA) Population 2008 estimates.

Source: DHSS Missouri Information for Community Assessment (MICA) Population 2003 estimates.

Source: DHSS Missouri Information for Community Assessment (MICA) Population 2008 estimates.

Narrative:
The estimated population in the 0 to 24 age group increased slightly from 1,980,780 in 2007 to 1,981,932 in 2008 (0.1%). The increase was observed among African-Americans (0.1%) and other (non-white 2.5%) race groups. The largest increase was among the 18 to 19 year olds (2.2%) and 1 to 4 year olds (2.1%). The total live births decreased by 1.2% from 2007 to 2008.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	76297	4525	0
Children 1 through 4	297461	21167	0
Children 5 through 9	360503	21301	0
Children 10 through 14	371877	16905	0
Children 15 through 19	397599	15061	0
Children 20 through 24	384915	14321	0
Children 0 through 24	1888652	93280	0

Notes - 2011
Source: DHSS Missouri Information for Community Assessment (MICA) Population 2008 estimates.

Source: DHSS Missouri Information for Community Assessment (MICA) Population 2008 estimates.

Source: DHSS Missouri Information for Community Assessment (MICA) Population 2008 estimates.

Source: DHSS Missouri Information for Community Assessment (MICA) Population 2008 estimates.

Source: DHSS Missouri Information for Community Assessment (MICA) Population 2008 estimates.

Source: DHSS Missouri Information for Community Assessment (MICA) Population 2008 estimates.

Narrative:
The estimated population of Hispanics in Missouri under age 25 increased by 4.2% from 89,550 in 2007 to 93,280 in 2008. This compared to a slight decrease (0.1%) in the non-Hispanic population for the same age group. The increase in the Hispanic population was across all sub-age groups except for birth population, which showed a 3% decreased from 2007 to 2008.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	74	29	41	0	0	0	3	1
Women 15 through 17	2368	1567	731	16	4	10	12	28
Women 18 through 19	6106	4419	1518	44	19	25	21	60
Women 20 through 34	61892	50493	8860	264	966	600	107	602

Women 35 or older	8185	6778	888	31	224	161	16	87
Women of all ages	78625	63286	12038	355	1213	796	159	778

Notes - 2011
Source: DHSS Vital Statistics. Provisional live birth numbers as of April 2010. Final numbers will be available November 2010.

Row "women of all ages" does not include women with unknown age.

Source: DHSS Vital Statistics. Provisional live birth numbers as of April 2010. Final numbers will be available November 2010.

Row "women of all ages" does not include women with unknown age.

Source: DHSS Vital Statistics. Provisional live birth numbers as of April 2010. Final numbers will be available November 2010.

Row "women of all ages" does not include women with unknown age.

Source: DHSS Vital Statistics. Provisional live birth numbers as of April 2010. Final numbers will be available November 2010.

Row "women of all ages" does not include women with unknown age.

Source: DHSS Vital Statistics. Provisional live birth numbers as of April 2010. Final numbers will be available November 2010.

Row "women of all ages" does not include women with unknown age.

Narrative:
Total live births decreased by 2.8% from 2008 to 2009 (provisional). The proportion of births to women under 18 was 6.4% in African-Americans and 2.5% in whites in 2009. Compared to the 2000 birth rate (per 1000) for all races, the 2008 birth rate decreased in teens under 18 while it increased across other age groups:
10-14: 0.7 (2000) vs. 0.2 (2008)
15-17: 26.7 (2000) vs. 21.6 (2008)
18-19: 80.4 (2000) vs. 83.1 (2008)
20-34: 104.3 (2000) vs. 107.7 (2008)
35-44: 18.5 (2000) vs. 21.2 (2008)

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	69	5	0
Women 15 through 17	2169	198	1
Women 18 through	5738	361	7

19			
Women 20 through 34	58543	3272	77
Women 35 or older	7725	448	14
Women of all ages	74244	4284	99

Notes - 2011
Source: DHSS Vital Statistics. Provisional live birth numbers as of April 2010. Final numbers will be available November 2010.

Source: DHSS Vital Statistics. Provisional live birth numbers as of April 2010. Final numbers will be available November 2010.

Source: DHSS Vital Statistics. Provisional live birth numbers as of April 2010. Final numbers will be available November 2010.

Source: DHSS Vital Statistics. Provisional live birth numbers as of April 2010. Final numbers will be available November 2010.

Source: DHSS Vital Statistics. Provisional live birth numbers as of April 2010. Final numbers will be available November 2010.

Narrative:
The live birth rate in the Hispanic population decreased by 5% from 2008 to 2009 (provisional). The birth rate for women under 18 was 4.7% in Hispanics and 3% in Non-Hispanics in 2009. Compared to the 2000 Hispanic birth rate (per 1000), the 2008 rate decreased in teens age 15 to 17 and increased in the other age groups:
15-17: 48.6 (2000) vs. 47.1 (2008)
18-19: 118.4 (2000) vs. 154.9 (2008)
20-34: 137.8 (2000) vs. 161.7 (2008)
35-44: 31.9 (2000) vs. 37.3 (2008)

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	557	380	166	2	5	0	3	1
Children 1 through 4	113	79	34	0	0	0	0	0
Children 5 through 9	57	42	12	1	2	0	0	0
Children 10 through 14	54	35	17	2	0	0	0	0
Children 15 through 19	295	201	92	2	0	0	0	0
Children 20 through 24	421	320	94	3	2	0	0	2
Children 0	1497	1057	415	10	9	0	3	3

through 24								

Notes - 2011
Source: DHSS Vital Statistics. Provisional infant death numbers as of April 2010. Final numbers will be available November 2010.

Source: DHSS Vital Statistics. Provisional infant death numbers as of April 2010. Final numbers will be available November 2010.

Source: DHSS Vital Statistics. Provisional infant death numbers as of April 2010. Final numbers will be available November 2010.

Source: DHSS Vital Statistics. Provisional infant death numbers as of April 2010. Final numbers will be available November 2010.

Source: DHSS Vital Statistics. Provisional infant death numbers as of April 2010. Final numbers will be available November 2010.

Source: DHSS Vital Statistics. Provisional infant death numbers as of April 2010. Final numbers will be available November 2010.

Narrative:
Deaths of children age 0 to 24 decreased slightly from 1,544 (77.9 per 100,000) in 2008 to 1,497 (75.5 per 100,000) in 2009 (provisional). From 2008 to 2009 (provisional), the infant death rate (per 1,000) slightly increased in whites (5.9 in 2008 to 6 in 2009) while decreasing in African-Americans (15 in 2008 to 13.8 in 2009).

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	536	21	0
Children 1 through 4	110	3	0
Children 5 through 9	56	1	0
Children 10 through 14	52	2	0
Children 15 through 19	285	10	0
Children 20 through 24	413	8	0
Children 0 through 24	1452	45	0

Notes - 2011
Source: DHSS Vital Statistics. Provisional infant death numbers as of April 2010. Final numbers will be available November 2010.

Source: DHSS Vital Statistics. Provisional infant death numbers as of April 2010. Final numbers will be available November 2010.

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Source: DHSS Vital Statistics. Provisional infant death numbers as of April 2010. Final numbers will be available November 2010.

Narrative:
Deaths of Hispanic children age 0 to 24 decreased slightly from 46 (49.3 per 100,000) in 2008 to 45 (48.2 per 100,000) in 2009 (provisional). Hispanic infant deaths decreased slightly from 23 (5.1 per 1,000) in 2008 to 21 (4.9 per 1,000) in 2009 (provisional).

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	1582696	1300002	242748	11016	28930	0	0	0	2008
Percent in household headed by single parent	32.8	26.1	69.9	55.2	0.0	45.9	45.9	0.0	2008
Percent in TANF (Grant) families	7.4	5.2	19.2	4.3	1.2	0.0	0.0	0.0	2009
Number enrolled in Medicaid	547254	369708	155251	1041	4598	901	4078	11677	2009
Number enrolled in SCHIP	118591	88939	24917	205	1285	155	473	2617	2009
Number living in foster home care	14333	9919	4031	44	30	13	142	154	2009
Number enrolled in food stamp program	521699	339280	163847	944	2764	825	3748	10291	2009
Number enrolled in WIC	152662	99473	32770	249	1779	0	1907	16484	2008
Rate (per 100,000) of juvenile crime arrests	4325.7	3527.0	8329.2	898.6	784.6	0.0	0.0	0.0	2008
Percentage	4.2	3.0	9.2	4.7	2.1	0.0	0.0	0.0	2009

of high school drop-outs (grade 9 through 12)									

Notes - 2011
Source: Bridged 2008 population estimates from the National Center for Health Statistics. The number under category Asian includes numbers under categories Asian/Native Hawaiian/other Pacific Islander. Total for more than one race reported was not available.

Source: US Census Bureau. American Community Survey 2008. Table S0901. The numerator was single parent households with children under 18 years of age and denominator was all households with children under 18 years of age. Difference from last year due to only hispanic white percentage was provided.

Number of TANF recipients aged 0-19 years served in State FY 2009 was obtained from the Missouri Department of Social Services, Research & Evaluation Unit.

Non SCHIP Medicaid children 0-19 years of age served in State FY 2009: Missouri Department of Social Services, Research & Evaluation Unit.

SCHIP Medicaid children 0-19 years of age served in State FY 2009: Missouri Department of Social Services, Research & Evaluation Unit.

Number of food stamp recipients aged 0-19 years served in State FY 2009 was obtained from the Missouri Department of Social Services, Research & Evaluation Unit.

Field Note:
Number enrolled in WIC: Number of children aged <5 years enrolled in WIC in CY 2008. Data source: CDC. 2008 Pediatric Nutrition Surveillance System (PedNSS), Missouri - Summary of Demographic Indicators.
Race classifications defined for HSI # 9 are not completely comparable with those applied by the PedNSS data report. White category only included Non-Hispanic White; Black category only included Non-Hispanic Black; Asian category included Asian/Pacific Islander; Other and Unknown category (HSI#9A) included Hispanic and Other/Unknown categories.

Source: Dept of Social Services (possible duplicates) from calendar year 2008. Duplicates are due to inconsistencies between circuits and counties. Represents juvenile referrals only-not arrests.

Hispanic/nonhispanic drop out rate is 2009 federal fiscal year (July 1, 2008-Sept 2009) from the Dept of Elementary & Secondary Education.

Highschool drop out rate is the number of dropouts divided by (September enrollment plus transfers in minus transfers out minus dropouts added to total September enrollment then divided by two).

Number of children living in foster home care served in State FY 2009 was obtained from the Missouri Department of Social Services, Research & Evaluation Unit.

Narrative:
From 2008 to 2009, the number of children ages 0 to 19 receiving food stamps increased by 44,723 (9%). The number of Medicaid recipients in the same age group increased by 40,575

(8%). Although the overall high-school drop-out rate held steady at 4.2%, the African-American drop-out rate slightly increased from 9.0% in 2007 to 9.2% in 2008.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	1503737	78959	0	2008
Percent in household headed by single parent	32.4	39.4	0.0	2008
Percent in TANF (Grant) families	7.3	8.1	0.0	2009
Number enrolled in Medicaid	506593	36871	3790	2009
Number enrolled in SCHIP	110921	6764	906	2009
Number living in foster home care	13722	439	172	2009
Number enrolled in food stamp program	490630	27482	3587	2009
Number enrolled in WIC	136178	16453	31	2008
Rate (per 100,000) of juvenile crime arrests	4468.9	1598.2	0.0	2008
Percentage of high school drop-outs (grade 9 through 12)	3.9	4.8	0.0	2009

Notes - 2011
Source: Bridged 2008 population estimates from the National Center for Health Statistics.

Source: US Census Bureau. American Community Survey 2008. Table S0901. The numerator was single parent households with children under 18 years of age and denominator was all households with children under 18 years of age.
Difference from last year due to only hispanic white percentage was provided.

Number of TANF recipients aged 0-19 years served in State FY 2009 was obtained from the Missouri Department of Social Services, Research & Evaluation Unit.

Non SCHIP Medicaid children 0-19 years of age served in State FY 2009: Missouri Department of Social Services, Research & Evaluation Unit.

SCHIP Medicaid children 0-19 years of age served in State FY 2009: Missouri Department of Social Services, Research & Evaluation Unit.

Number of food stamp recipients aged 0-19 years served in State FY 2009 was obtained from the Missouri Department of Social Services, Research & Evaluation Unit.

Field Note:
Number enrolled in WIC: Number of children aged <5 years enrolled in WIC in CY 2008. Data source: CDC. 2008 Pediatric Nutrition Surveillance System (PedNSS), Missouri - Summary of Demographic Indicators.
Race classifications defined for HSI # 9 are not completely comparable with those applied by the PedNSS data report. White category only included Non-Hispanic White; Black category only included Non-Hispanic Black; Asian category included Asian/Pacific Islander; Other and Unknown category (HSI#9A) included Hispanic and Other/Unknown categories.

Source: Dept of Social Services (possible duplicates) from calendar year 2008. Duplicates are due to inconsistencies between circuits and counties. Represents juvenile referrals only-not arrests.

Hispanic drop out rate is 2009 federal fiscal year (July 1, 2008-Sept 2009) from the Dept of Elementary & Secondary Education.
Nonhispanic drop out rate is 2008 federal fiscal year (July 1, 2007-Sept 2008) from the Dept of Elementary & Secondary Education.

Highschool drop out rate is the number of dropouts divided by (September enrollment plus transfers in minus transfers out minus dropouts added to total September enrollment then divided by two).

Number of children living in foster home care served in State FY 2008 was obtained from the Missouri Department of Social Services, Research & Evaluation Unit.

Narrative:
Among children 0 to 19 years of age, the proportion of Hispanics increased from 4.8% in 2007 to 5% in 2008. This group represents 7% of the Medicaid recipients.

From 2007 to 2008, the proportion of Hispanics increased from 5.3% to 5.7% among children in SCHIP, and increased from 4.8% to 5.3% among children in the food stamp program. The rate per 100,000 of Hispanic juvenile crime referrals increased from 1,572 in 2007 to 1,598 in 2008.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	1177383
Living in urban areas	1098502
Living in rural areas	484194
Living in frontier areas	0
Total - all children 0 through 19	1582696

Notes - 2011
Source: US Census, Population Estimate Branch. Metropolitan area is based on metropolitan statistical area counties in 2003.

Source: US Census Bureau. American Community Survey 2008.
The urban/rural number for 2008 was estimated using the 2008 population estimate and an estimated urban/rural split for 2008, which was extrapolated from the urban/rural splits for the 1990 and 2000 Census.

Source: US Census. American Community Survey

Narrative:
The estimated percentage of children age 0-19 living in rural areas was 30.6% in 2008. This compares to 31.7% in 2007.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	5860596.0
Percent Below: 50% of poverty	4.4
100% of poverty	13.3
200% of poverty	31.9

Notes - 2011
Source: US Census. Current Population Survey, Annual Social and Economic Supplement, 2009. Data represents 2008 population in poverty universe.

CPS Table Creator: http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

Source: US Census. Current Population Survey, Annual Social and Economic Supplement, 2008.
CPS Table Creator: http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

Source: US Census. Current Population Survey, Annual Social and Economic Supplement, 2008.
CPS Table Creator: http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

Source: US Census. Current Population Survey, Annual Social and Economic Supplement, 2008.
CPS Table Creator: http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

Narrative:
An estimated 31.9% of Missourians lived in households with income under 200% of federal poverty level in 2008. This compares to 30.5% in 2007.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	1578189.0
Percent Below: 50% of poverty	5.7
100% of poverty	19.0
200% of poverty	39.1

Notes - 2011
Source: US Census. Current Population Survey, Annual Social and Economic Supplement, 2009. Data represents 2008 population age 00-19 in poverty universe.
CPS Table Creator: http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

Source: US Census. Current Population Survey, Annual Social and Economic Supplement, 2009.
CPS Table Creator: http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

Source: US Census. Current Population Survey, Annual Social and Economic Supplement, 2009. Data represents 2008 population age 00-19
CPS Table Creator: http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

Source: US Census. Current Population Survey, Annual Social and Economic Supplement, 2009.
Data represents 2008 population age 00-19
CPS Table Creator: http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

Narrative:
An estimated 39.1% of Missouri children age 0 to 19 lived in households with incomes under 200% of federal poverty level in 2008. This compares to 41.7% in 2007.

F. Other Program Activities

Text4baby

DHSS joined as an outreach partner with the National Healthy Mothers, Healthy Babies Coalition to promote text4baby, a free texting service that sends messages to participants' cell phones. The service will provide health information from pregnancy through a baby's first year. Plans are to distribute text4baby posters LPHAs and to include text4baby information as part of the other health education materials provided by the DHSS. As of April 30, 2010 there were 1,223 Missourians who had enrolled in the text4baby service.

TEL-LINK

TEL-LINK is the Department of Health and Senior Services' (DHSS) confidential, toll-free information and referral line for maternal, child and family health services. Callers are given referrals and then are transferred immediately to the appropriate agency. The TEL-LINK program collaborates with other MCH programs through the use of its toll-free number to promote healthy birth outcomes and healthy infants. During FFY2010, the TEL-LINK number was posted on the new DHSS website for "Perinatal & Postpartum Depression." The website gives viewers information and brochures that may be ordered by calling the toll-free number.

Outreach is provided through the TEL-LINK website, exhibits at conferences and health fairs and through advertising in various parenting and health magazines to promote TEL-LINK. The program was promoted for the first time this year at a Women's Correctional Center's health fair. Collaboration with other programs, such as Missouri Head Start, has allowed the TEL-LINK number to become known to head start agencies throughout the state.

Parenting Corners

Genetics and Healthy Childhood (GHC) is funding the construction of 21 Parenting Corners for distributing parenting materials to Department of Corrections (DOC) offenders at 21 facilities as part of the DOC Restorative Justice Reentry Program. GHC will contribute literature including Basic Child Development, Safety, Exercise and Nutrition, Mental Health, Substance Abuse/Prevention, Education, Special Populations, and Legal. Each Parenting Corner will also feature a drop-box where offenders can submit specific questions. The first Parenting Corner was ready for placement May 1, 2010.

Denim Day

Denim Day is an annual, international rape education and awareness campaign. The DHSS, Office on Women's Health (OWH) coordinates Denim Day in Missouri and supports the organizations participating by furnishing Denim Day toolkits, lapel pins, bookmarks, flyers and posters along with technical assistance free for Missouri participants. There were over 310 events across Missouri in 2010 with colleges/universities, junior high/high schools, State Departments,

Local Public Health Departments, not-for-profit agencies, Army and Air Force Bases and private businesses participating. The Denim Day website www.supportdenimday.com ,Twitter and Facebook presence is utilized to promote Denim Day.

H1N1

At the center of Missouri's response to the H1N1 influenza pandemic was a statewide mass vaccination campaign. The 115 local public health departments were the gatekeeper within each county to control the distribution and reporting of H1N1 to providers, hospitals, etc.

A flu clinic locator was developed and posted on the DHSS website so consumers could identify the location of H1N1 clinics. Several school clinics were held with great success. To accompany these efforts, a comprehensive statewide communication and public education campaign was launched to encourage Missourians to protect themselves and their families by getting vaccinated. The campaign included print advertisements, radio and television messages, billboards, mass transit advertisements, newsletter articles, news releases, Facebook and other on-line advertisements. Many of the advertisements were translated in Spanish and Bosnian and a strong emphasis was placed on targeting hard-to-reach populations in rural areas of the state.

To assist medical providers seeking detailed consultation on a wide variety of related issues, DHSS activated its Nurse Hotline. While it was activated, the DHSS Nurse Hotline operated 24/7 from April 27-May 11 and received more than 800 calls. It was reactivated in October 2009 to respond to an influx of calls related to a news release announcing H1N1 vaccine availability in Missouri. The nurse volunteers answered hundreds of calls regarding vaccine availability, priority groups, clinic locations, flu signs and symptoms and when to seek medical care.

DHSS contracted with the Missouri Regional Poison Center to handle H1N1 calls through its hotline to assure continued public access to an H1N1 hotline. A dedicated hotline number was established and promoted statewide. Known as the Missouri H1N1 InfoLine, the hotline contract relieved a growing burden on DHSS personnel and resources. At the time of this update, the H1N1 InfoLine had received approximately 10,000 calls since it began operation.

Since October 2009, more than 1.6 million doses of the H1N1 vaccine have been shipped to Missouri and preliminary reports indicate that more than 750,000 doses of the H1N1 vaccine have been administered across the state.

SAFE-CARE

SAFE-CARE (Sexual Assault Forensic Examination-Child Abuse Resource and Education) Network, administered by DHSS and supported by a Medical Director and Advisory Council, provides training and support to physicians and nurse practitioners who conduct medical evaluations of alleged victims of child maltreatment.

Women's Health

The Office of Women's Health Network is comprised of organizations and individuals concerned with women's health. The Network provides timely information about current issues in women's health, such as changes in services for women, changing technology in women's health, funding opportunities, resources, and pertinent state legislative updates. It reaches every county in the state.

Health Literacy

In December 2009, Health Literacy Missouri (HLM), the nation's first statewide center devoted solely to increasing health literacy opened for business in St. Louis. The mission of HLM is to improve the health of all Missourians by providing access to plain language healthcare

information, offering educational resources that help healthcare providers communicate effectively with patients, creating systematic change at the point of medical care, improving health literacy through education and community collaborations, and strengthening the evidence base for health literacy. The group's website, www.healthliteracymissouri.org, provides users free access to an online library of health literacy materials.

G. Technical Assistance

Technical assistance requests under consideration include:

-Implementation of the "Lifecourse" perspective. Missouri has chosen to implement the "Lifecourse" perspective as the overarching theme for the 2010 State Priorities. It became apparent as part of the needs assessment process that the "Life Course" perspective was a method of addressing each of Missouri's priority needs as opposed to a specific priority of its own.

-Expansion of Medical Home. Much has been written and discussed regarding MH in Missouri. Missouri has utilized several "factors" in selecting a best measure of "promotion of medical home", such as how many children have a primary care provider listed. Technical assistance from an outside source, such as the American Academy of Pediatrics, is being requested to identify specific measures of "medical home" to determine the "best" measure of "promotion of medical home" in Missouri.

- Healthy Birth Outcomes/Infant Mortality. Technical Assistance is needed to identify challenges in programs, agencies and/or policies to allow for corrective action and address Missouri 2010 Priority Needs of reducing disparities in adverse birth and pregnancy outcomes and reducing intentional and unintentional injuries among infants.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	14185831	13021865	13024136		13236586	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	10614374	13249895	9680697		12036562	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	25000	4726	35000		4000	
6. Program Income *(Line6, Form 2)*	1000000	0	1000000		0	
7. Subtotal	25825205	26276486	23739833		25277148	
8. Other Federal Funds *(Line10, Form 2)*	120774626	90296396	141276145		177154471	
9. Total *(Line11, Form 2)*	146599831	116572882	165015978		202431619	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	1782078	2113335	1486073		3114394	
b. Infants < 1 year old	1950833	1889647	1749461		3503169	

c. Children 1 to 22 years old	9365476	10541095	8812755		10259805	
d. Children with Special Healthcare Needs	8252474	7573072	7418103		6360423	
e. Others	3075226	2882131	2996275		742171	
f. Administration	1399118	1277206	1277166		1297186	
g. SUBTOTAL	25825205	26276486	23739833		25277148	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	100000		100000		93713	
c. CISS	0		0		0	
d. Abstinence Education	885593		885593		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	113846133		134825574		99699355	
h. AIDS	0		0		0	
i. CDC	5502544		5074020		16573096	
j. Education	0		0		0	
k. Other						
Early Childhood	140356		105000		140000	
Newborn Hearing	0		0		298937	
Other USDA Grants	0		0		58556096	
Primary Care Offices	0		0		222727	
Rural Acces to Emer	0		0		100000	
Rural Hospital Flex	0		0		494547	
Sm Rur Hosp Improv	0		0		396000	
State Loan Repayment	0		0		150000	
State Office of Rur	0		0		180000	
Traumatic Brain Inju	0		0		250000	
Newborn Screening	150000		150000		0	
Traumatic Brain Inj	150000		135958		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		**FY 2010**		**FY 2011**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health	1028275	1206994	565107		972624	

Care Services						
II. Enabling Services	6407900	5530142	5899004		6185659	
III. Population-Based Services	9555345	11569777	8875575		12003245	
IV. Infrastructure Building Services	8833685	7969573	8400147		6115620	
V. Federal-State Title V Block Grant Partnership Total	25825205	26276486	23739833		25277148	

A. Expenditures

The total Title V Block Grant amount awarded to the state in fiscal year 2009 was $14,185,831. From the amount awarded, $11,151,461 was expended in federal fiscal year 2009 due to carryovers from fiscal year 2008. The carryover amount from fiscal year 2008 was $1,870,404.

The amount of funds actually expended under the category "State Funds" was $2,615,249 more than the budgeted amount in fiscal year 2009. The increase in expenditures was due to a change in how match funding is reported for the Alternatives to Abortion and School Health programs.

The budgeted amount of $1,782,078 for the category "Pregnant Women" was less than the actual expenditures of $2,113,335 due to a change in how match funding is reported for the Alternatives to Abortion program.

The budgeted amount of $1,950,833 for the category "Infants < 1 Year Old" was more than the actual expenditures of $1,889,647 due to an increased number of vacant positions.

The budgeted amount of $9,365,476 for the category "Children 1-22 Years Old" was less than the actual expenditures of $10,541,095 due to a change in how match funding is reported for the School Health program.

The budgeted amount of $3,075,225 for the "All Others" category was more than the actual expenditures of $2,882,131 due to a change in how match funding is reported for PS expenditures.

The budgeted amount of $1,399,118 for the category "Administration" was more than the actual expenditures of $1,277,205. This was due to an over estimation of expenditures for the year.

The budgeted amount of $1,028,275 for "Direct Care Services" was less than the actual expenditures of $1,206,994 due to a re-evaluation of the percentages used to distribute costs among the MCH Block pyramid types of service.

The budgeted amount of $6,407,900 for "Enabling Services" was more than the actual expenditures of $5,530,142 due to vacant positions and a re-evaluation of the percentages used to distribute costs among the MCH Block pyramid types of service.

The budgeted amount of $9,555,345 for "Population Based Services" was less than the actual expenditures of $11,569,777 due to a re-evaluation of the percentages used to distribute costs among the MCH Block pyramid types of service.

The budgeted amount of $8,833,684 for the category "Infrastructure Services" was more than the actual expenditures of $7,969,573 due to various reasons. There were vacant positions throughout the year. This, in turn decreased the amount of Administration costs. There was also decreased state funding in the areas of Core Public Health and the SAFE CARE program.

B. Budget

The state's maintenance of effort level from 1989 is $9,987,230 and the state's match requirement for fiscal year 2011 is $9,927,440. The state's match budget for fiscal year 2011 is $12,040,562.

The "Federal Allocation" category for fiscal year 2011 is $13,236,586. This figure is based on the fiscal year 2010 grant award since the final grant award for fiscal year 2011 has not yet been determined.

There is a budget variation in Fiscal year 2011 regarding "State Matching Funds." Due to a change in how match funding is reported, DHSS is including additional match of $1,324,865 over the Fiscal Year 2010 budgeted amount. The additional match is reflected in the total variance percentages. This type of increase is not expected for future years.

There were significant budget increases to the Pregnant Women, Infants less than one-year old, and Children ages 1-22 categories due to several factors. There were state budget increases to the Alternatives to Abortion program and the State Public Health Lab (SPHL) Personal Service (PS), which now funds 19 FTE. These increases coupled with the re-evaluation of funding distribution contributed to the vast percentage increase to the budget. There were decreases to the CSHCN and All Others categories due to re-evaluation of funding distribution.

There were significant budget increases in Direct Care Services, Enabling Services, and Population-Based Services due to several factors. There were state budget increases to the Alternatives to Abortion program and the SPHL PS, which now funds 19 FTE. These increases coupled with the re-evaluation of funding distribution contributed to the percentage increase to the budget. There was a budget decrease to Infrastructure due to re-evaluation of funding distribution.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.